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Implementing Choices at Regional Facilities: Program Proposals for Women Offenders with Special Needs

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This research project has only been possible with the support of a large number of people within the Correctional Service of Canada. I would like to thank the women offenders and staff who have provided me with a unique opportunity to understand their lives within the federal penitentiaries in Nova Scotia and Ontario. I have done my best to honour their voices and experiences in synthesizing this report and developing program proposals. These proposals have greatly benefited from the stories, difficulties and lessons that they have shared with me. My hope is that they will be repaid by the implementation of more effective programs as the result of this research process.

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Executive Summary & List of Recommendations

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Recent reports on women offenders (Laishes, 1997; Rivera, 1996; Whitehall, 1995) consistently identify the importance of developing specialized programs and living options in the regional facilities for women with special mental health needs. Program alternatives are required so that they can live successfully in a least restrictive environment rather than having to remain in maximum-security facilities. The purpose of this study is to investigate the needs of these women and make specific recommendations and program proposals to support and assist them to be accommodated safely in the regional correctional facilities at a medium- or minimum-security classification.

The research has been limited to the Atlantic and Ontario regions as these two areas were identified at the outset as having the highest numbers of women with special needs who could be maintained in regional facilities, if special programs were in place. The program models recommended may be applicable to other regional facilities. The research process included a review of literature, offender files, and an extensive number of interviews with inmates, community stakeholders, and staff at diverse organizational levels at Nova Institution, the Springhill Women's Unit, Grand Valley Institution, and the Kingston Prison for Women.

I. Lessons from Past Experience

A review of the experience in penitentiaries in Atlantic Canada and Ontario with women with special needs over the past two years provides the following important lessons which must be incorporated into new program proposals:

1. *Diverse and Incompatible Needs:* There are distinctive constellations of needs among women with "special needs" that require distinctive program approaches. Women with very different needs can be incompatible in less secure environments, resulting in explosive situations.

2. *Relationship Issues Are Paramount:* These women have unstable and emotionally charged relationships that make larger group situations very difficult, if not dangerous. Their needs must be addressed through individual and small group interactions, including the ability to separate women from each other.

3. *Individualized and Intensive Learning Programs:* These women have entrenched and long-term behaviour patterns and change comes slowly

through programming and practice targeted on an individual basis to their learning styles and strengths.

4. *Supportive, Consistent and "Present" Staffing:* Experiences have been most positive when staff are regularly present with the women in their living environments such that they can establish supportive relationships with them. These women have difficulty establishing supportive relationships with staff if they are not present and have to be sought out.

5. Multi-Disciplinary Team Approach with Mental Health Expertise: Given the complexity of their difficulties, working with these women is extremely difficult and tiring for staff. A diversity of expertise is required and staff need a team approach to effectively support each other and the individual women. Mental health expertise is essential as well as correctional experience, and staff need on-going training and support. Effective communication among staff is essential or individuals will play staff off against each other.

6. Programs Require a Distinctive and Recognized Mandate in a Broader Institution: Specialized programs require a specialized structure and context that will have procedures which will depart from procedures across a broader institution. This must be recognized and agreed to at the outset.

7. Therapeutic Quiet Behaviour Management Options Are Required: Women with limited cognitive ability or those acting act due to extreme emotional distress in many instances need short term sanctuary or isolation in a therapeutic context akin to options available in a psychiatric setting, rather than a formal segregation process.

8. The Physical Facilities Must Be Designed to Meet Program Need:. The physical design must follow from the needs of the women and the program structure. The design must also be flexible given that programs and needs are likely to change over time.

9. Stigma and Labeling Issues Must Be Addressed: There will inevitably be stigma with respect to participation in special programs, and specific measures must be taken to recognize and reduce it.

II. Principles and Processes of Specialized Mental Health Programs

Specialized mental health programs, including the program proposals outlined in this report are to be structured and delivered under the auspices of the Mental Health Strategy for Women Offenders (Laishes, 1997). The key principles of this strategy are: wellness, access, women-centred, client participation, and least restrictive measures. The Mental Health Strategy also details a number of other essential elements/principles in the delivery of mental health services which are particularly appropriate to these proposals: consistent structure and environment, effective integration and information sharing, bridging to other services and the community, and quality staff training and education.

III. Identification of Women with Distinctive Constellations of Special Needs

The women offenders presently in maximum-security environments who could be maintained with additional and alternative program resources at the regional facilities must be distinguished by their constellation of needs: those with basic skill needs and cognitive challenges, and those with emotional distress needs. A third group of women in maximum-security environments may require intensive programming to assist them in changing anti-social attitudes and behaviour, but when they are ready, they can function within the regular programs at the regional facilities. Efforts to mix these groupings in the past have proven inappropriate and explosive.

Two distinct program models are required: a psychosocial rehabilitation (PSR) program model for women with basic skill needs and cognitive challenges, and a dialectical behaviour therapy (DBT) model for women with emotional distress needs who have severe behavioural difficulties. There are a very few women with emotional distress needs who are suffering from acute episodes of a major mental illness. If the new program models recommended here are implemented, it is judged that the existing resources and facilities can meet the needs of these women offenders.

IV. Psychosocial Rehabilitation Program Model For Women with Basic Skill Needs and Cognitive Challenges

Psychosocial rehabilitation has its conceptual roots in a response to the failure of the mental health system to assist disabled clients in coping with the psychosocial devastation brought on by severe mental or emotional illness, severe behavioural problems and traditional treatment methods (i.e., institutionalization and medication; Nel, 1994). Women with basic skill needs and cognitive challenges in federal penitentiaries have similar characteristics, backgrounds, and histories of institutionalization. Their successful return to the community is halted by...

- their limited resources, skills, and supports,
- their isolation, sense of hopelessness and despair brought on by institutionalization,
- their deviant behaviour patterns learned through institutionalization,
- their loss of community learning opportunities and supports that accompanied institutionalization.

Based on this perspective, the psychosocial rehabilitation field brought together three applied programming models in the 1980s in order to develop an effective means to support the recovery of these persons: (1) "Psychiatric Rehabilitation" (Anthony, Cohen & Farkas, 1990), (2) the "Clubhouse Model" (Beard, Propst, & Malamud, 1982), and (3) "Assertive Community Living" (Stein & Test, 1986). The PSR field has now evolved and expanded to become the most prominent conceptual approach in North America to working with persons with severe emotional disabilities and impairments. The approach is based on (1) the experiences and voices of consumers demanding participation and self-determination in treatment, (2) the recognition that core values such as hope, empowerment, and determination are essential to recovery, and (3) the importance of targeted skill development and specific environmental supports as means to overcome impairments and enable individuals to function effectively in normal social roles and community settings. The specific issues essential to the development of an effective psychosocial rehabilitation program for these women are outlined in sequence below along with specific recommendations for program implementation.

Conceptual Approach of Psychosocial Rehabilitation: The psychosocial rehabilitation approach is the most appropriate and potentially effective programming model for individuals with basic skill needs and cognitive challenges such that they can reside in the least restrictive environment in a regional facility. The approach must be adapted to the regional penitentiary setting by staff trained in the psychosocial rehabilitation approach. A disproportionate number of women in Canadian penitentiaries with basic skill needs and cognitive challenges come from Atlantic Canada.

> *Recommendation 1:* Implement the psychosocial rehabilitation approach for women offenders with basic skill needs and cognitive challenges through a specific program model appropriate for the regional facilities, which incorporates relevant elements of psychiatric rehabilitation, the clubhouse model, and assertive community living. This model shall reflect the specific strengths and limitations of the women with this constellation of needs and be based on a specific purpose and set of objectives. The psychosocial rehabilitation program model should initially be implemented as a pilot project at Nova Institution in Truro, Nova Scotia.

Admission Criteria and Assessment Process: Matching the needs of individuals with the program goals and structure is essential to success. Inappropriate mixes of women offenders will compromise the effectiveness of the program and represent a major threat to its effectiveness. This is a particular problem given the potential for operational pressure to place inappropriate women in the program simply as a result of their needing higher levels of supervision.

> *Recommendation 2:* A formal, written, multi-disciplinary assessment process with admission criteria based on the consent of the woman offender, a medium or minimum security classification, significant basic skill needs, significant cognitive challenges, and the need for staff supervision, is required for entry into the program. There must be an official, approved program description with clear admission criteria which requires staff at the regional facility to make the final decision on admission.

Individual Program Planning: The psychosocial rehabilitation planning technology incorporates some traditional mental health planning approaches such as careful assessment and structured skills-teaching. It differs from traditional approaches in several important ways: goal setting precedes skills-teaching, emphasis on the need to overcome barriers in order to commit to change, explicit core values, and an explicit client-driven technology.

> *Recommendation 3:* The individual programming with women

> with basic skill needs and cognitive challenges should be driven by the psychosocial rehabilitation technology process in which staff practitioners competent in the approach develop partnerships with the women offenders on an individual basis. Supportive relationships between the women offenders and a consistent and small number of staff are required to support this process.

Characteristics of the Physical Living Environment: It is important to provide these women with a small group living environment which simultaneously provides a home-like appearance that mirrors community standards, while also insuring safety and security in instances of acting-out behaviour. Staff expertise and input from women offenders is required to balance these design criteria.

> *Recommendation 4:* Plan and construct a duplex house with up to four women living on each side (8 per duplex) at the regional facility utilizing the proposed structure and criteria as a starting point for planning. The architects must utilize staff expertise, and input from relevant women offenders, to plan the house. The program coordinator must be hired as soon as possible such that the coordinator is able to facilitate staff and offender input into the design. A committee made up of the lead architect, the builder, the warden, and the PSR coordinator must have the final authority on all phases of the design and construction process.

Daily Living Expectations and Skills-teaching: The living environment is an important context in which these women can learn basic skills and take on practical responsibilities, but they will require assistance and support from staff to do so. Learning is most effective when it is a deliberate, structured part of carrying out daily living tasks with extensive feedback built into the process. Interpersonal communication difficulties will be an ongoing issue and a valuable forum through which the women can learn problem-solving skills.

> *Recommendation 5:* Staff should plan skills training in order to take advantage of daily activities that are completed as a part of the regular lifestyle as teaching opportunities. Interpersonal communication and relationships should also be utilized as a context for teaching social skills. Skills-teaching action plans should be based on the psychosocial rehabilitation plan. Daily structured meetings should be held to facilitate management of daily tasks, interactions and responsibilities in the home.

Work, Learning, and Leisure Programs and Skills: These women are typically fearful of new learning situations given their past histories of failure in community settings. On the other hand they often value meaningful, structured and practical tasks where they receive positive feedback and recognition. They have a particular affinity for art and music.

> *Recommendation 6:* Deliberate individual and small group activities defined through each person's psychosocial rehabilitation plan should provide opportunities for integration into regular programs, specific work and service projects, participation in creative arts activities for self-expression and awareness, and the development of a sense of ownership in the living setting. A clubhouse philosophy should guide this programming so as to

promote recognition through work and service, and teach skills through practical experiences.

Behaviour Management in the Living Environment: These women have long term behavioural difficulties that will inevitably manifest themselves and they must be addressed effectively in a team context. There is a potential serious conflict between the emphasis on choice and empowerment which is fundamental to these women establishing hope, confidence, and a stake in their own lives, and behavioural programs and consequences that may be required to manage difficult behaviours.

> *Recommendation 7:* Staff must balance the need for hope and empowerment inherent in psychosocial rehabilitation with the need to cope with offenders' behavioural difficulties. Setting the appropriate balance should involve the use of group-defined house expectations, natural contingencies, multi-disciplinary team meetings, staff reflection on values and interaction style, and a continuum of quiet options.

Therapeutic Quiet: Women with basic skill needs and cognitive challenges may lose control of their behaviour and/or act out such that they require short-term, externally locked control and clear consequences, be it for a few minutes or a few hours. However, lengthy isolation is counter-productive as the offender loses focus on why she is isolated, and she may become more desperate, hopeless and dependent. Invoking segregation is often inappropriate for the circumstances and yet a brief therapeutic quiet option is required if segregation is to be avoided.

> *Recommendation 8:* Therapeutic quiet must be an essential element of the duplex design through which women can learn to better manage stressful situations, and through which they can be secured when a danger to themselves. Specific written procedures must be developed to monitor its use. Staff must be trained in its use. Medication may also be a useful tool to assist women in stressful situations but its use requires stringent monitoring and written procedures.

Stigma Versus Peer Support and Teaching: These women may be viewed by other offenders, and other members of the community, in a range of ways varying from disdain and rejection to solidarity. Frequently their experience has been one of isolation, rejection, and stigma. If the women in the PSR program become severely stigmatized by others, they will reject the program for themselves and act out to disrupt it. On the other hand, other women offenders have expressed a willingness to help and work with them on an individual basis in a structured and time-limited context.

> *Recommendation 9:* Stigmatization and labeling of these women offenders poses a serious threat to the success of the program and should be minimized or avoided through: a peer support program, peer education, facilitation of a sense of ownership in their home, adherence to the admission criteria, and their integration into regular programs.

Bridging for Community Integration: The present correctional release process is ineffective for women with basic skill needs and cognitive challenges due to its failure to provide a bridge of consistent relationships for the women to the community setting. There must be a process through which to advocate for and develop individualized plans, including education of community support systems.

> *Recommendation 10:* There must be an alternative release model in which a community integration worker builds a strong relationship with the individual woman in the penitentiary and then uses this relationship as a bridge to establishing her in a supported community setting. Sufficient funds must be provided to support this community integration process. The community integration worker must be based in the institution in order to develop the strong relationship with the individual offender that is required for success.

Staffing Complement, Qualifications, and Roles: High quality and committed staff are essential to an effective program. They must be committed to both direct work with difficult women and to the PSR program model. Although staffing is expensive for a program for these women with special mental health needs, insufficient or poorly trained staff will result in failure. The recommended staffing level is lower than the level of a maximum-security facility where these women would otherwise be maintained.

> *Recommendation 11:* It is essential to select staff with strong interpersonal skills and values for work with these women while allowing for a mix of expertise to provide for diverse perspectives. Programming will be most effective if there is a small, multi-disciplinary staff who can support each other and provide a consistent approach to work with the women. Core staffing should include a program coordinator and a community integration worker, two PSR workers on day and evening shifts, a night security staff, and a part-time psychologist, occupational therapist, and program evaluation consultant. Part-time PSR worker positions should be avoided wherever possible, as intermittent staff presence makes communication and coordination more difficult. Night staff should only work on night shifts with a security and supervision function.

Staffing Training, Support, and Communication: Effective staff training and support is essential to the success of the program and the ability to attract and retain quality staff.

> *Recommendation 12:* All core staff must participate in an eight week training program including six weeks of training in psychosocial rehabilitation, one week of training in clubhouse and assertive community living approaches, and one week devoted to team building, program planning and evaluation, and selected mental health topics. A brief training program should be provided for auxiliary staff. There must be on-going commitment and resources for staff communication and support.

Program Evaluation: Program evaluation is essential to program improvement and accountability.

> *Recommendation 13*: Either a team member with evaluation

expertise or an external consultant should design and conduct the program evaluation in consultation with the staff team and the woman offenders.

Obstacles to Effective Implementation of the Program: The following issues could become major obstacles to the implementation of an effective program and therefore must be recognized and strategically addressed from the outset: failure to hire and/or maintain quality staff, conflicts with broader penitentiary policies and requirements, inability of the staff team and the local administration to control planning decisions, and a rapid and ineffective transition process for individual women transferring from maximum-security facilities.

> *Recommendation 14:* Specific strategies must be adopted from the outset to overcome these obstacles.

V. Dialectical Behaviour Therapy and Programming For Women with Emotional Distress Needs

Dialectical Behaviour Therapy (DBT) represents one of the most prominent approaches to work with women with borderline personality disorder in North America and has clinical research utilizing controlled trials to support its effectiveness (see Linehan, 1993). A majority of the women offenders with high emotional distress needs exhibit a combination of similar difficulties characterized by self-destructive and/or suicidal behaviour, emotional dysregulation, severe interpersonal relationship problems, unstable and low self-image, and cognitive disturbances and distortions The DBT model has been applied in forensic settings and appears to offer the most promise of available approaches for work with these women. A disproportionate number of women with these difficulties are in Ontario. Therefore, it is proposed that this model be initiated as a pilot project for a structured treatment program and living environment at Grand Valley Institution in Kitchener Ontario. This program should (1) serve women already present at Grand Valley who are not able to cope with life in regular houses due to their emotional distress and severe behavioural difficulties, and (2) allow some women in maximum-security facilities to be supported and maintained at regional facilities.

Before describing the proposed DBT program model, it is important to note that there remains a small group of women with emotional distress needs (four persons at present) who are suffering from the acute symptoms of major mental illness who would not be appropriate for a DBT program. Existing mental health resources, assuming that new resources are put in place for the DBT and PSR programs, are sufficient to serve these women with the exception of a serious deficiency in psychiatric nursing at the regional facilities.

> *Recommendation 15:* New nurses hired within the regional facilities should be required to have psychiatric training and/or experience. Existing nurses should be offered an extensive inservice training program to upgrade relevant mental health and substance abuse expertise for working with women offenders. Existing psychiatric nurses at the Prison for Women would be helpful in defining the training program.

Conceptual Basis For Dialectical Behaviour Therapy: The DBT approach for working with these women is rooted in three philosophical and therapeutic traditions: cognitive-behavioural approaches, humanist relationship approaches, and dialectical theory. Linehan (1993) identifies 8 assumptions (core values) as essential to the DBT approach. She emphasizes the need for practitioners to maintain a hopeful approach and avoid blaming the women for their behaviour and difficulties. It is also important to obtain the offender's agreement and commitment to reduce her self-injurious behaviours and work toward a better future, even if she can not foresee success.

DBT defines a hierarchy of behavioural targets for change across three stages of treatment such that the individual focuses on lower priority targets as their control over their behaviours increases and higher level targets are achieved. This hierarchy of behavioural targets provides the priority list for what is addressed through the treatment program, although there are distinctions as to which targets receive priority in each component of treatment. A particular strength of this approach is the emphasis on agreed upon behavioural priorities as women with these needs typically have an unending series of crises that make it extremely easy for both staff and offenders to lose focus on treatment priorities.

> *Recommendation 16:* Implement the dialectical behaviour therapy approach for women offenders with emotional distress needs and severe behavioural difficulties at Grand Valley Institution in Kitchener, Ontario through a specific program model which is appropriate for regional facilities. This model shall reflect the specific strengths and limitations of the women with this constellation of needs and be based on a specific purpose and set of objectives. Given the limited clinical resources presently at Grand Valley and the high demands on those who are present, it is recommended that senior staff from Prison for Women who are familiar with DBT approaches serve as consultants to Grand Valley Institution in setting up the DBT program.

Admission Criteria and Assessment Process: Matching the needs of individuals with the program goals and structure is essential to success. Inappropriate mixes of women offenders will compromise the effectiveness of the program and represent a major threat to its effectiveness. This is a particular problem given the potential for operational pressure to place inappropriate women in the program simply as a result of their needing higher levels of supervision.

> *Recommendation 17:* A formal multi-disciplinary assessment process with admission criteria based on the consent of the woman offender, a medium- or minimum-security classification, significant coping, communication and problem-solving skill needs, and the need for staff supervision, is required for entry into the program. There must be an official, approved program description with clear admission criteria which requires staff at the regional facility to make the final decision on admission.

Components of DBT Treatment: There are four interrelated components to conducting a DBT program and there must be overall effective coordination between them by the multi-disciplinary staff team.

> *Recommendation 18:* The individual counseling and coaching, group skills training, daily meetings, and informal staff consultation components must be implemented in a coordinated manner by a multi-disciplinary staff team with specific training in the approach. The DBT program should also be accessible to a limited number of women with emotional distress needs who are able to cope in regular houses with the extra support provided by the program.

Characteristics of the Physical Living Environment: It is important to provide women with emotional distress needs and severe behavioural difficulties with a small group living environment which simultaneously provides a home-like appearance that mirrors community standards, while also insuring safety and security in instances of acting-out behaviour. Staff expertise and input from women offenders is required to balance these design criteria.

> *Recommendation 19:* Plan and construct a duplex house with up to four women living on each side at the regional facility utilizing the proposed structure and criteria as a starting point for planning. The architects must utilize staff expertise, and input from relevant women offenders, to plan the house. The program coordinator must be hired as soon as possible such that the coordinator is able to facilitate staff and woman offender input into the design. A committee made up of the lead architect, the builder, the warden, and the DBT coordinator must have the final authority on all phases of the design and construction process.

Daily Living Expectations and Skills Application: The women offenders should be responsible for daily living tasks as in the regular houses. However, given their emotional instability and difficulties with relationships, there are likely to be difficulties in the process of working together and completing tasks. These difficulties will be valuable learning opportunities in which staff can coach and facilitate the women offenders to apply the core DBT skills to daily living problems. Informal interaction and leisure opportunities between individual women, and between individuals and staff are an important means to develop the trusting relationships and provide opportunities to address problem-solving and coping issues through the application of the core skills.

> *Recommendation 20:* Staff should utilize informal interactions as a means to foster trusting relationships with the women. Emphasis should be placed on using difficulties resulting from conflicts generated by relationship and/or daily living tasks as opportunities for individuals to apply their coping and problem-solving skills to practical situations. The amount of staff supervision may vary over time in relation to the specific grouping of women. It should balance needs for staff to develop strong relationships with the women, to provide for the safety of everyone, and to foster the independent functioning of the women.

Work, Learning, and Leisure Programs and Skills: Emphasis must be on insuring that these women are fully integrated into the general population with respect to work and leisure opportunities as the expectation is that they will eventually move into a regular house or an unsupported community living situation.

> *Recommendation 21:* Excepting their involvement in DBT specific program components, women in the duplex would participate in general programming in relation to their correctional plans like any other woman offender.

Behaviour Management in the Living Environment: These women have long term behavioural difficulties that will inevitably manifest themselves and they must be addressed effectively in a team context. There is a potential serious conflict between the emphasis on individuals taking responsibility for their behaviour utilizing DBT skills, which is fundamental to these women establishing hope, confidence, and a stake in their own lives, and behavioural programs and consequences that staff may utilize to manage difficult behaviours.

> *Recommendation 22:* Staff must balance the need for hope and personal motivation inherent in dialectical behaviour therapy with the need to cope with offenders' behavioural difficulties. Setting the appropriate balance should involve the use of group-defined house expectations, natural contingencies, dialectical concepts, multi-disciplinary team meetings, staff reflection on values and interaction style, and a continuum of quiet options.

Therapeutic Quiet: Women with emotional distress needs may be at risk for self-harm such that they may seek or require short-term, externally locked control, be it for a few minutes or a few hours. However, lengthy isolation is counter-productive as the offender loses focus on why she is isolated and she may become more desperate, hopeless and dependent. Invoking segregation is often inappropriate for the circumstances and yet a brief therapeutic quiet option may be required.

> *Recommendation 23:* Therapeutic quiet must be an essential element of the duplex design through which women can learn to better manage stressful situations, and through which they can be secured when a danger to themselves. Specific written procedures must be developed to monitor its use. Staff must be effectively trained in the use of therapeutic quiet.

Bridging for Community Integration: The present correctional release process is ineffective for women with emotional distress needs and severe behavioural difficulties due to its failure to provide a bridge of consistent relationships for the women from the penitentiary to community settings. These women require consistent relationships to make a successful transition across settings. Behavioural gains made in the DBT program will be lost, including a greater likelihood of recidivism, if there is not consistent and effective support provided in transitions.

> *Recommendation 24:* There must be an alternative release model in which a community integration worker builds a strong relationship with the individual woman in the penitentiary and then uses this relationship as a bridge to establishing her in a community setting. The community integration worker must be based in the institution in order to develop the strong relationship with the individual offender that is required for success. Sufficient

> funds must be provided to support this community integration process. Consistent relationships with DBT staff must also be maintained if a woman moves from the DBT duplex to a regular house within the penitentiary.

Staffing Complement, Qualifications, and Roles: High quality and committed staff are essential to an effective program. They must be committed to both direct work with difficult women and to the DBT program model. Although staffing is expensive for a program for these women with special mental health needs, insufficient or poorly trained staff will result in failure. This staffing level is lower than the level of a maximum-security facility where these women would otherwise be maintained.

> *Recommendation 25:* is essential to select staff with strong interpersonal skills and values for work with these women while allowing for a mix of expertise to provide for diverse perspectives. Programming will be most effective if there is a small, multi-disciplinary staff who can support each other and provide a consistent approach to work with the women. Core staffing should include a program coordinator/psychologist, one DBT worker on day and evening shifts, a second psychologist, a community integration worker, and a program evaluation consultant. Night shift staff, if required, should not be DBT workers in the program and should be limited to a security and supervision function. Core part-time staff positions should be avoided wherever possible as their intermittent presence makes communication and coordination more difficult. It may be difficult to fill the coordinator position and it is recommended that senior staff from the Prison for Women assist with the recruitment and hiring process for key staff, as well as a professional with specific DBT expertise.

Staffing Training, Support, and Communication: Effective staff training and support is essential to the success of the program and the ability to attract and retain quality staff.

> *Recommendation 26:* All core staff must participate in a multi-week DBT training program designed in consultation with DBT specialists at the University of Washington in addition to two weeks of training on team-building, program planning, evaluation, and selected mental health topics. A brief training program should be provided for auxiliary staff. There must be on-going commitment and resources for staff communication and support, including supervision and peer support for the individual therapists.

Program Evaluation: Program evaluation is essential to program improvement and accountability.

> *Recommendation 27:* Either the psychologist or an external consultant should design and conduct the program evaluation in consultation with the staff team and the woman offenders.

Obstacles to Effective Implementation of the Program: The following issues could become major obstacles to the implementation of an effective program and therefore must be recognized and strategically addressed from the outset: failure to hire and/or maintain quality staff, conflicts with broader penitentiary policies and requirements, inability of the staff team and the local administration to control planning decisions, and ineffective team communication processes and insufficient support for staff.

> *Recommendation 28:* Specific strategies must be adopted from the outset to overcome these obstacles.

Conclusion

The proposed psychosocial rehabilitation program for women with basic skill needs and cognitive challenges and the dialectical behaviour therapy program for women with emotional distress needs and severe behavioural difficulties represent important new initiatives in relation to realizing the vision that was initially defined in *Creating Choices* by the Task Force on Federally Sentenced Women (1990). Up to this point the regional facilities have only provided one living option that has not met the needs of women with special mental health difficulties. As the result, these women have either ended up in difficult and often explosive situations in the regional facilities or have had to remain in maximum-security facilities. These two program models are a major step toward actually *implementing choices* at the regional facilities. They require more resources than is now allocated to programs at the regional facilities, but they require less resources than what is now allocated to maximum-security facilities. It must be recognized that these models will only be effective if they have quality staff and a significant level of resources committed to them. The costs will be much higher if these women have to remain in maximum-security facilities or serious incidents result from insufficient support for them at the regional facilities. In the long run these programs offer the promise of helping these women to make a successful transition to the community, for their own benefit and that of the society.

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Introduction & Purpose

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The publication and federal government acceptance in 1990 of *Creating Choices: The Report of the Task Force on Federally Sentenced Women* ushered in a new vision of correctional services for women offenders in Canada based on a plan to close the Prison for Women in Kingston, Ontario, and replace it with four regional facilities across the country and an aboriginal healing lodge. This plan was guided by five broad principles: empowerment, meaningful & responsible choices, respect & dignity, supportive environment, and shared responsibility. Although the document provided a vision for the development of the new facilities and systems, along with some specific recommendations, a detailed implementation process was required in order to bring it to fruition.

The implementation of the report put into place physical structures, staffing roles and patterns, and policies and procedures which had to respond to intervening program, financial, and political pressures. The result was one type of living facility in the new regional institutions in the form of houses of seven to ten individuals. The women in these houses are responsible for their own cooking, household chores, and immediate living environment with a minimum of supervision. This housing approach has worked well for a majority of women who find it liberating relative to the former prison culture of the Prison for Women. However, for a minority of women with special needs, the regional housing model has not worked. Individual women have not been able to function successfully in these houses, resulting in inmate assaults against staff or between inmates, acting out, and/or self-destructive behaviour. An experimental attempt to house women with special needs in a structured living arrangement at Nova Institution in 1996 ended in a violent incident. As the result of incidents in regional facilities, maximum-security women were shifted to separate secure facilities in the Springhill Institution, the Kingston Prison for Women, and the Saskatchewan Penitentiary. In addition, some women with a medium-security classification were transferred to these maximum-security institutions because they could not manage in the regional facility houses due to their special needs, particularly for more intensive mental health services.

Recent reports on federally sentenced women (Laishes, 1997; Rivera, 1996; Whitehall, 1995) consistently identify the importance of developing specialized programs and living options in the regional facilities for women with special mental health needs so that they can live successfully in a least restrictive environment. There is a Correctional Services requirement under the Corrections and Conditional Release Act that women be maintained in the least restrictive environment. In addition, the vision of *Creating Choices* is to establish living situations that mirror "community standards." In fact, the provision of one type of housing for all members of the society (regardless of its merit) does not mirror community settings where a range of living options are available for people with special needs. For example, women with severe mental health problems may move between settings based on their health status and need for structure, be it a supervised apartment, a small options home, or an independent living situation with outpatient support. For individuals in the community with cognitive limitations and difficult behavior, the trend has been to develop small options homes precisely because they have had difficulty functioning at an interpersonal level in group living situations.

The purpose of this study is to:

> ...investigate the needs of the women who require specialized programming and living options, and make specific recommendations and program proposals to support and assist them to be accommodated safely at the regional correctional facilities at a medium or minimum-security classification.

The research has been limited to the Atlantic and Ontario regions as these two areas were identified at the outset as having the highest numbers of women with special needs who could be maintained in regional facilities, if special programs were in place. The program models recommended may be applicable to other regional facilities.

The research process included an extensive number of interviews with staff at diverse organizational levels at Nova Institution, the Springhill Women's Unit, Grand Valley Institution, and the Kingston Prison for Women. Informal interviews were conducted with women with special needs at Nova, Springhill, and Prison for Women, and files and incident reports were reviewed at all four facilities (see Appendix A for a list of persons interviewed). At Nova, meetings were held with the Inmate committee and the Regional Advisory Committee for the Atlantic Region. The author met with the Inmate Committee, and representatives from the Elizabeth Fry Society and the Citizen's Advisory Council at Grand Valley. Relevant research literature and correctional services reports were reviewed (see bibliography) to broaden and deepen the expertise of the author who is a community psychologist with particular experience in working with persons with severe mental health problems and/or cognitive limitations in institutional contexts, and in program development and evaluation. He also has previous experience with community corrections. For many of the interviews with staff and inmates in the Atlantic Region, the author was accompanied by Donna Pineo, a nurse with extensive experience in managing psychosocial rehabilitation programs for persons with severe mental health and social functioning problems in institutions and the community. She served as a consultant in drafting this report.

Overall, the author attempted to hear from, honour, and integrate as many perspectives as possible in developing this report and the set of program proposals given a limited ten week, part-time framework. Although, individuals had distinctive ways of addressing the issues, and often emphasized different elements, most striking was a broad consensus on the issues that need to be addressed and the approaches which appear to hold the most promise. The report is divided into five sections: (1) review of the experiences with programming for women with special needs in the Atlantic and Ontario regions since the initiation of the regional facilities; (2) identification of the constellations of needs of the various groups of these women; (3) identification of the overall principles and processes through which programming options should be offered; (4) the psychosocial rehabilitation program proposal for women with basic skill needs and cognitive challenges; and (5) the dialectical behaviour therapy program proposal for women with emotional distress needs and severe behavioural difficulties.

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I. Programming Experiences with Women with Special Needs

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Women with Special Needs at Nova Institution
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Lessons For New Programs

Women with Special Needs at Nova Institution

Nova Institution opened in December of 1995 and it rapidly became apparent that there were individual women who were not coping with the new freedoms and level of responsibility in the houses. There was a fear of incidents among the women and a range of acting-out behaviours. Inmates who lived through that time at Nova report that they had a real concern for and willingness to help women who were functioning at a lower level in terms of basic hygiene, interpersonal and/or daily living skills. However, they found the pressure of this helper role to be immense when it was twenty-four hours a day in their living setting with minimal presence or support for these women with special needs from staff. Given that the women offenders doing the helping have difficulty tolerating frustration and stress on their own, it seemed inevitable that they would act out against the lower functioning women. In addition, there were women with special needs remaining in the Prison For Women for whom there was pressure to be returned to Atlantic Canada. Yet because it was recognized that these women could not cope in the regular houses, they had to remain in the Prison for Women until an alternative living option was available at Nova.

Given this context, the administration at Nova took quick action to provide an alternative and there was not time to do a careful pre-planning process, individual women had immediate needs. In March of 1996, an occupational therapist was hired to define and coordinate the program, and contract staff were put in place to provide 24-hour support and supervision in one regular house where the women with special needs were transferred. This "structured living house" continued to operate until late September of 1996, at which time violent incidents in this house and on the enhanced unit resulted in the closure of the special program and the transfer of the women who were involved to a new maximum-security environment at Springhill Institution. It is broadly recognized by a range of staff that there were very serious difficulties in the house across this period regardless of the specific events which triggered the incidents- they are beyond the scope of this report.

It is important to review the difficulties and accomplishments with respect to the "structured living house" as it provides key lessons for present efforts in establishing specialized programming at a regional facility. To this end, the author interviewed individual women who lived in the house, contract staff hired to provide support, primary workers at Nova responsible for the individual women and their correctional plans, the house coordinator, and members of the management team present at the time (see Appendix A). Documents describing the program were reviewed (Shimmel, 1996 & 1997).

Overall, there was a high level of conflict in the house and endless relationship problems and acting out among the eight women (Shimmel, 1997). When one woman appeared to be making strides, other women would sabotage her efforts. The Prison for Women culture was ever-present, "individuals who did attempt... positive changes were taunted, labeled as informants, and/or threatened to conform by other inmates who would identify them as not following "old code" behaviour such as that which sustains a `them and us' adversarial relationship with staff" (Shimmel, 1997, p. 3). Endless crises made it very difficult for staff to have the time and space to plan or put a new program into place as the house was already open. Despite the very difficult circumstances, activities and programming were developed over time: interpersonal difficulties were used as opportunities for women to learn problem-solving, functional assessments were completed, daily activity schedules were implemented, and household tasks were used as an opportunity to teach daily living skills. Some progress was observed with individual women in some skill areas (Shimmel, 1997).

There is a clear consensus as to the key issues in the functioning of the structured living house across all of the persons interviewed with respect to the experience. The specific areas of difficulty and accomplishment are highlighted below. In recounting and analyzing the difficulties, the focus must be on constructive learning for the future. The author's consistent impression is that both administrative and line staff were doing the best they could to cope with systemic difficulties- the need to take emergency measures to cope with women with special needs whom the original *Creating Choices* vision and plan had ignored.

Areas of Difficulty

(1) The Mix of Women. Everyone who was interviewed highlighted the broad and difficult mix of women living in the house as a primary source of problems. It is the foremost issue highlighted in the coordinator's review of the experience. In particular, there was a great diversity of difficulties, needs and incompatibilities among these women with special needs. Three constellations of issues were identified among these women. Some had significant intellectual limitations accompanied by significant deficits in daily living skills, basic social skills, and hygiene. They were assessed in the borderline or mildly mentally handicapped ranges of intelligence. Others were in the normal range of intelligence but had severe mental health problems with extreme emotional distress, persistent self-destructive behaviour, disassociations, distorted perceptions of themselves and others, etc. Finally there were women who were placed in the house because they were muscling and manipulating other women in the regular houses and were felt to be security risks who required more supervision. The "inmate code" was a primary issue with

these women. This mix in a small group living situation created a negative spiral of behaviour. Lower functioning women would react to the high emotional distress of women with mental health problems by acting out with similar self-destructive behaviours. Women with high levels of distress would be muscled or taunted by others and explode. Women carrying the code from Prison for Women would respond with anger and aggression to staff attempting to be supportive and involved, yet the staff did not have the training, nor the house the physical structure, to provide effective security responses. Largely, the structured living house was the only available supervised setting and thus the admission criteria became the need for supervision, rather than the need for a particular living situation and type of programming.

Staff recognized these difficulties at the time and are adamant that this mix not be repeated. Contract staff and primary workers feel that they gave enormous amounts of energy and caring, far beyond the normal expectations of their positions, to cope with and maintain the women in this living situation. When the violent incidents finally occurred, line staff felt blamed for their handling of the incidents when they believed they should have been acknowledged and supported for preventing them for such a long period, given the mix and explosiveness of the house. Whatever the specific events surrounding the incidents were, and the differing perspectives of them, there remains a deep bitter feeling among some staff that resurfaces when they consider a new proposal to serve these women. They indicate that they are philosophically and professionally committed to serving women with special needs at the regional facility, but they fear that there will not be enough resources to serve them and that operational constraints will repeat the explosive mix.

(2). Relatively Large Numbers and Relationship Issues. A second related set of difficulties involved the number of women in the house and the lack of interpersonal skills and relationship difficulties between them. Particularly for the lower functioning women, there was constant instability in their relationships. Alliances were ever shifting, two women would get into a conflict and refuse to be around each other one week and be best of friends the next week. Relationship conflicts and alliances would take precedence over all other issues and make it extremely difficult for staff to work with the women on practical skills. Correctional staff who have worked with both women and men consistently report that women are much more interpersonally oriented and the relationships between them are much more of a priority. This produced major difficulties with a group of six to eight, who had particular deficits in relationship skills, interacting in one small environment where they could not get away from each other. Although staff attempted to use the conflicts as a means to teach interpersonal skills and problem-solving, this is a lengthy, on-going process, particularly for the women with intellectual limitations. The speed with which conflicts arose, outpaced the ability of staff to work through them with the women.

(3). Staff Training, Communication, and Experience. The need to get the supervised house functioning very quickly meant that it was necessary to hire contract staff from outside of correctional services who generally had no experience in corrections and security issues. The pressures of the setting and their contract status made it difficult to provide them with broader training once they were hired. They found themselves thrust into a setting, attempting to defuse crises with limited experience, while

lacking key expertise in corrections and mental health. Moreover, the communication links were not well developed to the existing primary workers who were still responsible for case management functions and had important personal relationships with individual women. Thus, one contract worker articulated that there was little opportunity for her to communicate her perceptions of the various women and their needs to the case management team, even though she was spending eight hours a day with the women and the team had far more limited contact. On the other hand, some primary workers, with particular training and experience in social services, indicated that they came to their positions expecting to do more supportive and programming work with the women and yet found themselves restricted to security roles. Thus they would have liked to take on the supportive roles fulfilled by the contract workers and yet there was not the opportunity given their other duties. The differences in roles between the contract workers and the primary workers, and their differing sorts of relationships also provided extensive room for individual women to play one staff person off against another.

(4). Implementing Special Programs within a Broader Institutional Context. Another set of difficulties involved the need to implement specialized programs and to depart from standard procedures when there had not been a pre-defined mandate and rationale for the program at the outset. Staff in the house, lacking experience in the correctional system, were only able to identify and request the need for departures from regular practices as the issues arose. Then it would take time to process these requests through the administrative structure where concerns about departing from a standard set of procedures across the institution were important. Thus specialized daily schedules for women in the house would be an irritant to others in the institution who were expected to adhere to standard procedures for their schedules. In addition, given that the women in the house were also involved in regular programming and interacting with staff across the facility, specialized programs and approaches with these women had to be communicated across all of the primary workers given the regular shift rotations. This was a difficult and time-consuming process for the coordinator and contract staff, if only because of the number of people involved. Finally, security is inevitably a priority from an operational perspective in a penitentiary and was a reason for placing some of the women in the house. However, other women in the house had high emotional or programming needs without requiring high security procedures, which in fact were antagonistic to helping them to learn to function more independently.

(5). Problems with the Physical Structure. The only immediate option for physical accommodations for the women with special needs was in a regular house, one that was designed for a different purpose and this resulted in inherent difficulties. For example, the house was equipped to be in line with community standards such that it included a range of items from light bulbs to household chemicals that offered ample opportunities for self-destructive behaviours that were difficult to monitor. Contract staff, particularly at the outset, had to spend significant periods counting items that would have best been eliminated from the design of the house if it had been planned for women with higher levels of violence against themselves or others. The two floor design also made it difficult to quietly maintain a higher level of observation, and the stairs presented a physical hazard to lower functioning women with limited physical capacities. These women also required more space to get away from each other and yet the houses were built to provide for a group

living environment.

(6). Stigma & Labeling. Within the larger Nova population, the structured living house quickly became known as the "crazy house" because behavioural difficulties of one form or another seemed to distinguish the occupants. Lower functioning women inevitably have had to cope with a stigmatized status over long periods of their life but this was a more novel experience for some of the women who were there for security and mental health reasons (at least the magnitude of the stigma from their peers). One woman with high mental health needs indicated that she then responded to the labels by acting them out. The coordinator reports (Shimmel, 1997) that individual women frequently appeared to act out in order to have themselves removed from the house, which was the eventual result after the September 1996 incidents.

(7). Constraints on Developing a Coherent and Consensus Vision. Given that the program was designed on an emergency basis as the women were already living in the house, it was extremely difficult to create a broad consensus and clear vision for it among the management team and primary workers. There was a specific program proposal but not the time for the dialogue to clarify ideas and promote a consistent vision, including the program's relationship to the broader facility. As the result, different staff would bring differing criteria based on their positions and responsibilities to bear on decisions involving the program or the treatment of individual women within it.

Strengths in the Structured Living Program

Despite the diversity and magnitude of the difficulties outlined above, it is important to emphasize that those interviewed identified important strengths and some accomplishments. These areas also provide a valuable experience base from which to build future programs.

(1). Utilization of a Mental Health Treatment Model. It was felt that the mental health approach involving the provision of supportive relationships and experiential problem-solving in a more treatment-oriented context offered potential or was helpful for some of the women, particularly for those with practical skill deficits or severe mental health problems. Although the difficulties cited above hampered this model, staff gained experience over time that provided them with hope for on-going improvements. Contract staff found the time spent simply "being" with the women during the early months allowed them to develop relatively strong personal relationships with individuals, which could have been a foundation for change and growth. Unfortunately the relationship dynamics and mix of the house often prevented these relationships from supporting growth in the individuals.

(2). Mental Health Expertise. The provision of an occupational therapist as the coordinator who came from a mental health background and provided individual support and training for contract staff in occupational therapy and mental health was seen as a very valuable asset. Again, a number of those interviewed supported this approach and the critical need for a range of mental health expertise to make a program for women with special needs effective.

(3). Successes in Life Skills-teaching. Staff reported that some

individuals, particularly those with cognitive limitations, did gain specific life skills and confidence through the life skills programming that was a part of the program. This programming was seen as effective when there was repetitive practice on an individual basis, or when staff were working with small groups of compatible women. In fact, two women who were a part of the house are now doing well in the regular houses at Nova.

Treatment Issues and the Springhill Unit for Women

The women with special needs and/or maximum-security classifications were moved from Nova to a maximum-security unit at Springhill which was refurbished on an emergency basis. They have resided there up to the present and McDonagh (1998) has recently completed interviews with these women which investigate their perceptions of this setting, their needs, and the reasons for their ending up in a maximum-security facility. The author spent two days visiting this unit: interviewed staff and inmates with special needs, reviewed files, and read reports (Tobin, 1997). There have been serious acting-out behaviours on this unit over the 18 months of its operation, and the women report, as well as the staff, that they are extremely unhappy with the physical size of the unit and the lack of programming opportunities. The physical structure resembles a fish bowl in which small living areas are immediately adjacent to and in sight of each other, with the staff office in the middle. The on-going relationship problems and incompatibilities among inmates have required that small groups be segregated from one another at times. The physical structure has the security to provide for the locked physical separation, although noise travels across areas and provokes others.

Despite many difficulties, some of the women, particularly those with high mental health or security needs now report that the environment has had a positive impact on them in some ways. The small size of the unit, the regular immediate presence of a small number of staff, inmates' relationships to these staff, the ability to restrict drugs, the high level of structure, and the segregation from the pressures of a larger population of federally sentenced women, has resulted in some women from Prison for Women dropping the "code" and showing a willingness to embrace programming and rehabilitation. On the other hand, the limited programming opportunities, cramped environment, and high security has not been helpful to some of the lower functioning women who require basic skills programming. Much as at Nova, adversity and crisis management have provided insights into what can be helpful in future programming efforts.

Women with Special Needs at Grand Valley Institution

The author's interviews and research at Grand Valley Institution, the regional facility in Kitchener, Ontario, was limited to one day. Hence, there was inadequate time to gain a full picture of the issues and the perceptions of staff and inmates relative to the multiple days spent at Nova Institution and Springhill. The research was limited to an extended meeting with the management team, a meeting with representatives of the inmate committee, the Citizen's Advisory Committee, and the Elizabeth Fry Society, as well as a brief review of the files of some of the individual women which were presented by the management team.

The range of interviewees at Grand Valley presented similar perspectives on the difficulties faced in working with women with special needs at their institution, including many of the same concerns that had been expressed and experienced by Nova staff, Regional Advisory Council members, and inmates. There was consensus that there are a range of women with needs for special programming presently in Grand Valley whose needs are not being met due to inadequate staff resources, program options, and facilities. The management team identified eighteen women as needing specialized supports and exhibiting a wide range of difficulties: self-destructive behavior, dramatic attention-seeking and drug-seeking behaviour, depression and isolation, psychotic episodes, borderline personality characteristics, severe interpersonal relationship problems, and/or low cognitive functioning and basic skill deficits. A brief review of the files supported their perspectives of the range and severity of difficulties.

Inmate representatives expressed strong feelings that it was inappropriate and unjust for both the women with special needs and the women living with them to be co-existing in the same group living environment. They again expressed the view that women offenders are committed and willing to help those at lower levels of functioning within reasonable limits but that they were unable to cope with them on a twenty-four hour basis while sharing a home. They also felt it inappropriate that the women with special needs be restricted to the enhanced unit where there was not sufficient programming to meet their needs.

It seemed that the very limited psychology and mental health resources at Grand Valley, combined with an individual counseling model initiated at the discretion of the women, resulted in some of these women with serious difficulties living in the general population with very limited monitoring and supervision. Often women with high needs do not seek outpatient mental health treatment voluntarily or appropriately. They may require an inpatient, multi-disciplinary treatment approach where they are attended-to indirectly at the least, regardless of their reluctance to seek help, relative to an outpatient model in which they come at their discretion for weekly visits. The outpatient model may work appropriately and provide choices for a majority of the women, but may not be meeting the needs of women with more severe behavioural or mental health difficulties.

The Grand Valley management team expressed a firm commitment to try to maintain and work with these women with special needs within the institution at the medium-security level. They felt it was inappropriate to send medium-security women to the maximum-security Prison for Women unit, only because they did not have the resources to support them at Grand Valley, and would only do so if there was no other safe choice for the individuals. The circumstances that the management team reports seem similar to the situation which existed at Nova prior to the violent incidents in which the women with the most extreme behaviours were transferred to Springhill. The major difference relative to Nova has been that Grand Valley has twice the number of cells on the enhanced unit with higher security such that they have transferred women with higher needs to that area. Although this would not appear to be a suitable long-term or least restrictive living environment for these women, it does have the security structure to maintain control in a stressful situation. In a couple of other instances, Grand Valley has also transferred medium-security women with high needs to the maximum-security, special needs unit at the Prison for Women. Again, it would seem that women are being maintained there because there is no less restrictive environment with the program and living options necessary to safely support them. Overall, one must be concerned that the mix of women with high needs and difficult behaviours, along with staff who are putting high levels of energy into avoiding crises with them with inadequate resources, represents a recipe for a serious violent incident much as occurred at Nova.

Women with Special Needs at Prison for Women

The author spent three days at the Prison for Women (P4W), interviewing inmates, and staff, observing team meetings, reviewing files, and reading background documents relevant to recent programming efforts (Tobin, 1996 a & b; 1997 a & b). The plan had been to close Prison for Women and shift the women to a special unit at the Regional Treatment Centre (RTC) in the Kingston Penitentiary for Men. However, a law suit by some of the women opposed to this involuntary transfer, and the Elizabeth Fry Society, resulted in the Correctional Service of Canada agreeing to leave the women in Prison for Women until such time as an alternative facility could be provided which did not require transfer to the men's penitentiary. As the result, the Regional Treatment staff who were to work on the RTC unit were transferred to the Prison for Women in June of 1997. Over the past nine months, they have taken over responsibility for programming and are working with the correctional staff who were already present at the P4W. Given the short time period that the new staff have been in place, and the entrenched long-term nature of the problems which the women have with whom they are working, it is difficult to assess the outcomes. However a range of staff and inmates report that the new model demonstrates potential.

The following issues were noted through the interviews and the observations of the author:

High Level of Multi-Disciplinary Staff Resources: The P4W includes many of the women with the highest level of difficulties in the country and thus a high level of staff resources are required. P4W has this high level of resources with staff who come from a range of mental health disciplines: psychiatric nursing, psychology, behaviour science technicians, chaplaincy, consulting physicians, etc. This is striking in that Grand Valley and Nova do not have a proportionate level of resources relative to the numbers of women they serve and the level of their difficulties. This level of resources enables P4W to make important strides in programming and work with the women. Trained psychiatric nurses are a particular asset in this environment in that nurses in the regional facilities typically only have training in physical health and yet all of them are inevitably required to intervene with respect to psychiatric and physical health issues simultaneously. There are also behaviour science technicians (BSTs) at P4W who provide an extremely valuable resource to the program. The primary workers at the regional facilities tend to have a significantly higher level of training in mental health and social services than the correctional staff at Prison for Women, and thus could compensate for some of the expertise offered by the BSTs (particularly with some additional training). However, the job duties of the primary workers do not provide the time for them to focus on treatment issues as is the case with the BSTs. The BSTs also deliver programs which are staffed through individual contractors from the community at the regional facilities.

Multi-Disciplinary Team Approach: The program is specifically based on a multi-disciplinary team approach in which there is particular attention to communication across disciplines and a coordination of approaches with individual women. This process provides support for staff and fresh perspectives such that one or two people are not feeling entirely responsible for working with women with great difficulties. Women with special needs have a complex mixture of problems, issues, and behaviours such that the team approach seems essential in that it allows multiple staff perspectives to be utilized to make the best sense out of the women's experiences and difficulties.

Specialized and Individualized Programming: The programming approach and the staffing level allow the team to deliver support and programming to women with special needs in a more individualized format. The offenders appear to benefit from this specialization and there is the ability to avoid the incompatible relationships between the women that caused so many difficulties in the former structured living house at Nova. P4W is presently opening up another unit so as to sub-divide the special needs unit which now houses 11 women based on their experience of the diversity of needs and the importance of offering different programming to different groups. In particular, one group will have more freedom and less staff supervision than the other group.

Importance of Staff Relationships: Interviews by McDonagh (1998) indicate that in many instances the presence of correctional staff who are immediately on the special needs unit (most all of the time) has fostered positive relationships between the women and staff, promoting positive pro-social attitudes among the women. McDonagh did not observe the same level of relationships and their positive effects on the maximum unit next door where correctional staff are not stationed on the unit. Another important element of the relationship building is the BST role as they have the ability to spend informal time with the women in a supportive manner as well as providing supportive programming.

Multiple Options for Private Space When Under Stress-The Use of Therapeutic Quiet: P4W has implemented a therapeutic quiet procedure in which women can voluntarily request, or be placed by staff, in a empty or "stripped" cell on the unit for their own safety, particularly with respect to self-destructive behaviour. Women use this option relatively frequently and it seems to defuse crises and avoid the need for segregation. Unfortunately, the physical setting results in women having to be placed in cells on the unit with no sound proofing such that they are still exposed to the verbal goings on of other women, from whom they may need sanctuary. Staff recognize the importance of having multiple options for allowing a woman space when under stress, so that she can learn to take greater levels of responsibility for coping with stress without acting out. Heney (1990) reported that 97% of a sample of women interviewed from P4W, a majority of whom had previously engaged in self-injurious behaviour, indicated that segregation was an inappropriate response to self-injury and was perceived as punishment by the women.

The Quality and Structure of the Physical Environment: The physical environment at P4W has an oppressive and restrictive design and appearance that impacts on everyone living and working in it, as has been documented over many reports and many years (e.g., see *Creating*

Choices). As one person noted, "you can feel the pain in the walls." One experiences a feeling of hopelessness and it is an atmosphere that is in sharp contrast with the regional facilities that were designed to counter this environment. It seems particularly inappropriate as a place to house women with special needs who do not require a maximum facility. Yet at present there are no safe and appropriate options for these women at the regional facilities. However, it should be noted that for some women, this environment is home and it represents the only relationships they know, and at present there are more programming options available to them here. Movement of women from P4W, once appropriate programs are available elsewhere, must be an individualized and voluntary process which the women offenders work through with staff.

Lessons For New Programs

A review of the experience in penitentiaries in Atlantic Canada and Ontario with women with special needs over the past two years provides the following important lessons which must be incorporated into new program proposals:

1. *Diverse and Incompatible Needs:* There are distinctive constellations of needs among women with "special needs" that require distinctive program approaches. Women with very different needs can be incompatible in less secure environments, resulting in explosive situations.

2. *Relationship Issues Are Paramount:* These women have unstable and emotionally charged relationships which make larger group situations very difficult, if not dangerous. Their needs must be addressed through individual and small group interactions, including the ability to separate women from each other.

3. *Individualized and Intensive Learning Programs:* These women have entrenched and long-term behaviour patterns and change comes slowly through programming and practice targeted on an individual basis to their learning styles and strengths.

4. *Supportive, Consistent and "Present" Staffing:* Experiences have been most positive when staff are regularly present with the women in their living environments such that they can establish supportive relationships with them. These women have difficulty establishing supportive relationships with staff if they are not present and have to be sought out.

5. *Multi-Disciplinary Team Approach with Mental Health Expertise:* Given the complexity of their difficulties, working with these women is extremely difficult and tiring for staff. A diversity of expertise is required and staff need a team approach to effectively support each other and the individual women. Mental health expertise is essential as well as correctional experience, and staff need on-going training and support. Effective communication among staff is essential or individuals will play staff off against each other.

6. *Programs Require a Distinctive and Recognized Mandate in a Broader Institution:* Specialized programs require a specialized structure and context which will have procedures which will depart from procedures across a broader institution. This must be recognized and

agreed to at the outset.

7. Therapeutic Quiet Behaviour Management Options Are Required: Women with limited cognitive ability or those acting out due to extreme emotional distress in many instances need short term sanctuary or isolation in a therapeutic context akin to options available in a psychiatric setting, rather than a formal segregation process.

8. The Physical Facilities Must Be Designed to Meet Program Needs: The physical design must follow from the needs of the women and the program structure. The design must also be flexible given that programs and needs are likely to change over time.

9. Stigma and Labeling Issues Must Be Addressed: There will inevitably be stigma with respect to participation in special programs, and specific measures must be taken to recognize and reduce it.

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II. Identification of Women with Special Needs

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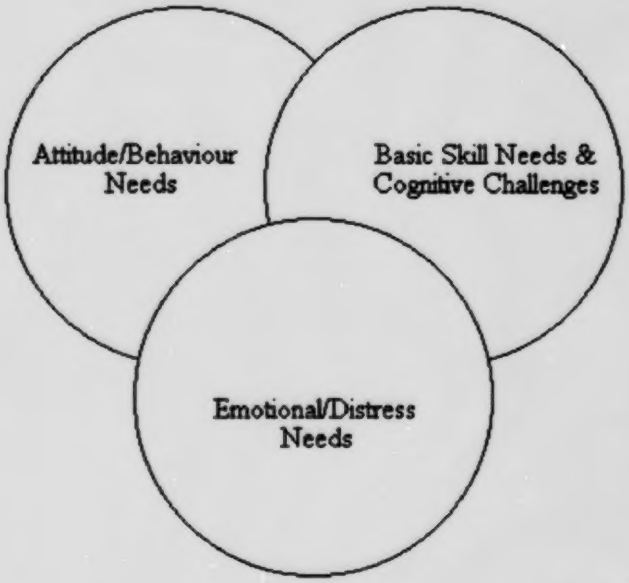
Although there has been a recognition that women with special functioning and mental health needs have very individual circumstances and characteristics, they have ended up being grouped together for the purposes of research and planning (Rivera, 1996; Whitehall, 1995) in relation to their "high" needs and inability to function in the housing and programming presently available in the regional facilities. This categorization by exclusion has at times resulted in grouping them as if there are significant commonalties among them which can be addressed through common programs. Moreover, when special programs are established, there is operational pressure to access them for anyone who needs higher levels of supervision which can in turn result in incompatible and/or contradictory mixes of individuals (e.g., the Nova structured living house). A large number of the staff and the federally sentenced women who were interviewed indicated that it is essential to describe different constellations of needs and generate different programming proposals based on these constellations.

The "Constellations of Special Needs" concept was identified and used during the interviews as a valuable tool which could provide a foundation from which to group needs and develop programming proposals (Earl, 1998). Three constellations of special needs are represented by circles which overlap each other to produce what mathematicians label a vend diagram (see Figure 1). In particular, one circle of special needs is characterized by women who have challenged or borderline intellectual functioning and a deficiency of basic life skills, a second constellation of needs involves those with special emotional problems relating to either extreme and persistent distress and/or a major mental illness, and a third set of needs describes those with a high level of distrustful attitudes and anti-social behaviour. While some women may be categorized as having needs primarily in one sphere, others may fall in an overlapping area representing two, or even all three areas. Needs change with time and in relation to the demands and characteristics of the prison setting such that a person might shift positions toward one circle or another. Needs may also vary in intensity with the ultimate hope, at least for some, that their needs would lessen such that they

Figure 1: Constellations of Special Needs

Among Federally Sentenced Women



could function successfully in the existing houses without specialized programming and structure, thus moving toward increased independence and responsibility. Finally, any grouping concept has to recognize that each person is unique and there are inevitably complex interactions and middle ground between groupings.

The subsequent discussion of the numbers of women in each grouping of needs is tentative and based on brief discussions with the women, interviews with staff who work with them on an intensive basis, and some file reviews. This process is not appropriate as a means to propose individual decisions on placement which would depend on the choices of the women and the full multi-disciplinary assessment process proposed for each program. However, this review does provide a numerical context in which one can roughly identify the numbers in the various groupings and determine the need for program type and size accordingly.

Basic Skill Needs & Cognitive Challenges. These women have intellectual limitations and have important needs with respect to basic interpersonal, social, daily living, and self-care skills. There are presently six women from Atlantic Canada in maximum-security facilities at Springhill or P4W whose needs seem to fall primarily within this grouping. They are high needs/low risk women who remain in maximum facilities because they require levels of staff supervision and support not now available within regional facilities. Staff in both facilities believe that their needs can be met in regional facilities if the resources are in place and if they are committed to making the transition. Three at Springhill express the desire to go to Nova if it were possible. A fourth is Inuit and has applied to go to the Aboriginal Healing Lodge and it remains to be seen if she can be accommodated there. She indicated a desire to go to Nova relative to remaining in Springhill. One more has had previous difficulties at Nova and has just moved from Springhill to P4W by choice. She has spent much of her life in highly structured and institutional environments and is comfortable within them, hence might be hesitant to move in the near future and could easily act out if she were forced to move. There are also two women now at Nova who fall in this grouping. One has been doing well in a regular house at Nova in large part due to the high level of support offered to her by other women in the house. The second woman has only been at Nova for a few weeks and it remains to be seen whether she will be successful in coping with the regular living accommodations. Both of them would benefit from specific life skill programming which might accompany a new program at Nova for this grouping. However, if they can function effectively within the regular houses with peer support, this may provide them with more independence. One of these woman particularly depends on a few inmates who may find it difficult to continue their high level of support over time.

An informal review of the women on the Special Needs Unit at P4W from outside the Atlantic Region with the Head Psychologist and Director of Programming, Dr. Fred Tobin, indicated that there was one woman with clear cognitive limitations and basic programming needs along with three others who have basic skill needs, a low level of daily functioning, and significant learning difficulties. A review with the Grand Valley management team of women with serious difficulties within their institution, identified two individuals with significant basic skill needs and behaviour problems combined with borderline intellectual functioning.

Overall, there appear to be six women presently in the Ontario region with needs within this constellation and up to eight Atlantic Canadians (see Table 1). Ten of the fourteen are now housed in maximum-security facilities. Relative to its population and number of federally sentenced women, Atlantic Canadians make up a disproportionately large percentage of this grouping. Only one is from a First Nations culture which is low relative to the overall percentages among federally sentenced women. These numbers will fluctuate over time as individual women are released and others move into the system. Although some of these women do not have long-term sentences, their pattern in the community is to re-offend in a relatively short period as they have a history of institutionalization and an inability to function with higher levels of independence. Unless there are major changes in community support systems and in their ability to function, they are likely to be long-term residents of the penitentiary system. The numbers in this grouping are unlikely to significantly decrease over time without major changes in correctional and support services.

Table 1: Numbers of Women with Special Needs in Ontario and Atlantic Canada

	Nova	Springhill	Prison for Women	Grand Valley	Totals
Basic Skill Needs & Cognitive Challenges: Potential for Medium-security	2*	4	5-6**	2	13-14
Basic Skill Needs & Cognitive Challenges at			0-1		0-1

Maximum-security					
Emotional Distress Needs: Potential for Medium-security		1	3***	6@	10
Emotional Distress Needs at Maximum-security		1	3		4
Attitude & Behaviour Needs at Maximum-security		2	12****		14
Totals	2	8	24	8	42

* These women need special programs but may not necessarily require an alternative living environment.

** Two of these women are from Atlantic Canada, including the one who is questionable for this category at present.

*** One of these women is from Atlantic Canada.

**** Some of these women are awaiting re-classification and transfer to medium-security at Grand Valley while there are also women at Grand Valley who may require transfer to maximum-security at P4W.

@ It is difficult to assess numbers in this category as Grand Valley staff presented 4 additional women with significant emotional distress who for the moment are doing better with special supports in the regular houses. These women might move into needing more support or those not now coping may move out of needing it.

Emotional/Distress Needs. This constellation of needs is in itself very disparate but refers to a wide range of people who have difficulties which primarily are associated with severe mental health problems such as depression, disassociation, extreme anxiety, persistent self-injury, schizophrenia, manic-depressive illness, eating disorders, etc. Their ability to perform basic life skills, and their level of cognitive functioning in the average range, separate them in terms of needs from the previous group. However, it is more difficult to distinguish them from women with high levels of need who might be in the third constellation characterized by distrustful attitudes and anti-social behaviours. Some of these behavioural characteristics such as depression, self-injury, extreme anxiety, etc., are exhibited by most women in a penitentiary at particular time periods, given the pressure and stress of the environment and their personal situations. Moreover, women who may be angry, distrustful, and sticking to the "inmate code" in one setting or time period, may seek help and share serious mental health problems in another situation. Or women who may have originally sought help for major mental health problems, may turn to anger and acting out when their needs are not met.

Keeping these issues in mind, there are women with a distinct constellation of needs for whom their mental health problems are primary, persistent and extreme such that they require more support and supervision than is available within the regular houses at the regional facilities, yet they do not necessarily require maximum-security environments. If they remain in regular houses, they isolate themselves, pose a high risk to self-injury, or possibly suicide, are unable to manage their own emotional distress, and/or produce chaos in the interpersonal relationships in the house which may end in violence. These women can be distinguished from women who have a pattern of anti-social attitudes and behaviour and require higher levels of security, core correctional programs, and clear consequences for their actions. For example, Tobin (1997b) coordinated a broad multi-disciplinary file review of the needs of the twenty-six women at P4W on more than one hundred variables. Three constellations of variables were identified: items related to criminal behaviour and belief systems, items related to treatment and life skill needs addressed in core correctional programs, and items related to emotional and psychological factors and/or major mental disorders. A correlational analysis identified that the twenty-six women could be divided into two clusters of needs. "Cluster one may be seen as individuals who have a criminal belief system and who exhibit a number of deficits in life skills, coping behaviour, etc... The second cluster captures those women who primarily present with mental health needs" (Tobin, 1997b).

Within the emotional/distress constellation of needs are two sub-groups, the first suffering from major mental illnesses with active psychoses, and the second expressing acute and persistent distress through their words and behaviour patterns. At present, there are two women at P4W with persistent psychotic illnesses with active symptoms, both of whom are viewed to require this maximum-security environment for the foreseeable future. Two women at Grand Valley are identified by the management team as actively psychotic and in distress in the regular houses. There are no women for whom a major psychotic illness is the primary presenting issue in Atlantic Canada although two women in the basic skills grouping described above have a diagnosis of schizophrenia, yet the psychotic symptoms have not been evident in recent years.

The second sub-group of women expressing "acute distress" is relatively larger. They exhibit diverse difficulties that include depression, extreme anxiety, self-injury and self-damaging behaviours, substance abuse, emotional instability, problems with anger, extreme interpersonal problems, and/or a distorted self-image. The label of "borderline personality" is now very "current" in the psychiatric literature, particularly in relation to women, and has been applied to a significant number of them. This diagnostic labeling approach remains controversial and the most prominent issue is that these women express and demonstrate unique combinations of needs and behavioural difficulties that are of an emotional nature and which prevent them from coping in the regular houses at regional facilities, yet they could be supported in medium-security environments with appropriate programs. They have in a number of cases entered the correctional system because mental health support and inpatient treatment has been cut back or closed to them at a community level. Their sentences vary in severity and length, but again, those with shorter sentences are likely to return to prison in a relatively short period if their emotional issues are not addressed and effective support systems are not available to them in the community.

There are two women in Springhill who are viewed by staff as having high emotional needs. One is viewed as appropriate for a medium-security environment with significant supports whereas it is felt that the other requires a maximum-security environment for the foreseeable future. Two other women at Springhill are viewed differently depending on the respondents, but are generally seen as being able to function in the regular Nova houses when they are ready for a medium-security environment. No one at Nova is now unable to function in the regular houses due to acute distress, although two women who would have been viewed as in this grouping, have been released in the past year.

In Ontario at P4W, three women are viewed as having high acute emotional distress needs, who could function in a medium-security environment with higher levels of support and programming than is now available. One woman exhibits acute emotional distress and is seen to require a maximum-security environment. The Grand Valley management team additionally identified six women who are not coping in the regular houses due to acute emotional distress. Three of them are presently residing on the Enhanced Unit to provide increased support and supervision. Four pose significant threats for self-injury. In addition, the Grand Valley management team identified four other women who have been through periods where they were not able to cope in the general population and/or require special support from health staff to continue to function in the regular houses.

Overall, Ontario appears to have the higher need for programming for women with emotional distress. The "active psychosis" sub-group is very small and restricted to Ontario. The acute distress sub-group includes three women at P4W and approximately six at Grand Valley who require special supports to function at the medium-security level. Only one woman in Atlantic Canada is presently viewed as having acute distress needs who could be supported at the regional facility with special programming.

Attitude & Behaviour Needs. Women with this constellation of needs are viewed as requiring intensive programming and security based on patterns of anti-social attitudes and behaviour, escape risk, and/or institutional adjustment. Although they may have important mental health needs and require particular attention if they are to move to a regional facility, their ability to successfully move from a maximum-security to a medium-security environment is not based on intensive mental health programming and/or alternative living accommodations in the regional facility. Key issues are their openness to change and core programming, and their institutional behaviour. These women are not within the mandate of this study and were not interviewed nor reviewed at length with staff. Two women were identified as falling within this constellation of needs at Springhill and there are now twelve women on the maximum-security range at P4W. These women have been interviewed and considered in depth as part of the work of SkyBlue Morin and Donna McDonagh in their reviews of aboriginal and non-aboriginal women with maximum-security classifications, projects that occurred simultaneously with this research project.

Summary of Analysis of Constellations of Needs. The women offenders presently in maximum-security environments who could be maintained with additional and alternative program resources at the regional facilities must be distinguished by their constellation of needs: those with cognitive challenges and basic skill needs, and those with emotional distress needs. A third group of women in maximum-security environments may require intensive programming to assist them in changing their attitudes and behaviour, but when they are ready, can function within the regular programs at the regional facilities. Given the distinct sets of needs with respect to women in the cognitive and basic skills grouping relative to those in the emotional distress grouping, two distinct program models are required and proposed in this report. Efforts to mix these groupings in the past have proven inappropriate and explosive.

Between Springhill and P4W, there are 13 or 14 women presently housed in maximum environments who have potential for being supported in the regional facilities with specialized and alternative programs (see Table 1). The high number of women presently at Grand Valley in emotional distress are only being managed with the use of the eight-cell enhanced unit. The potential for a serious incident there is high if specialized resources and living arrangements are not provided to that facility for the women who are already there. Women with cognitive and basic skill needs are disproportionately from Atlantic Canada while women with emotional distress needs are disproportionately from Ontario.

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III. Principles and Processes of Specialized Mental Health Programs

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Subsequent sections propose two distinct program models for the regional facilities based on the distinction between women with primarily cognitive challenges and basic skill needs and those primarily with emotional distress needs. Both models are mental health programs and therefore are to be structured and delivered under the auspices of the Mental Health Strategy for Women Offenders (Laishes, 1997). The key principles of this strategy are described below in relation to these programs. Please refer to pages seven and eight of the Mental Health Strategy for the original description of the principles in their broader context.

1. Wellness

· Programs are to be delivered in a holistic fashion that "recognizes body, mind, spirit and emotions and their interconnectedness in a family and community-oriented context" (p. 7).

· Labels are to be avoided and are not criteria for admission to these programs insofar as they obscure the unique needs of each individual. The programs must also include provisions to reduce the stigma and labels that may be placed on them by other offenders.

· Programs are to focus on teaching and reinforcing community skills rather than simply learning to adapt to an institutional environment.

· Programs must work through a multi-disciplinary process that includes mental health professionals as well as other important resources, including aboriginal service providers, community resources, and families, etc.

2. Access

· Programs must provide for early identification of problems and needs, timely intervention, and programming in keeping with community standards.

3. Women-Centred

· These programs "must be offered in a gender specific and gender appropriate manner such that:

- only personnel sensitive to women and women's issues are involved.

- programs and services are designed to meet the specific needs of women offenders while acknowledging personal autonomy, connection to others, and positively mutually respectful relationships" (p. 8).

4. Client Participation

· "Women offenders must be involved in their assessment and treatment such that they play as active a role as possible in their treatment planning and decision-making" (p. 8). Participation in these programs is to be voluntary and based on input from the individual woman. It must be recognized that participation in one of these programs may be required for some women if they are to live at a regional facility.

5. Least Restrictive Measures

· These programs are to be provided at the regional facilities in order to provide the "least restrictive/intensive form of intervention possible, while ensuring public safety" (p. 8), in order to maximize the amount of responsibility for these women in their daily lives and normalize their living environment relative to community standards.

The Mental Health Strategy also details a number of other essential elements/principles in the delivery of mental health services which are appropriate to these proposals (see pages 8-13 of the Mental Health Strategy; Laishes, 1997). Several of these elements are of particular priority given the needs of the women and are therefore considered as additional key principles for these programs.

6. Structure and Environment

· "Consistent structure and environment are central to the success of programming endeavors" (p. 9). This is particularly important for women with higher levels of needs. A key element to maintaining a consistent structure involves having a consistent set of relationships through which the individual women can learn to trust in others and themselves. Consistent, trusting relationships are an essential building block of both program proposals.

7. Integration and Information Sharing

· "Management must ensure that the model of mental health delivery integrate all related activities that are part of the continuum" (p. 10). Although part II of this report distinguishes differing constellations of needs among women with special needs, it is essential that the unique needs and circumstances of each woman are given priority and inevitably there will be important and difficult decisions as to how to best serve each woman. Therefore it is proposed that there be one multi-disciplinary assessment and decision-making process for all of the women referred to these special programs within an institution. The decision on type of program must reside with the woman and the multi-disciplinary team so as to avoid conflicts between programs over suitability, or operational pressure on one individual that could serve to over-rule the multi-disciplinary, decision-making process.

8. Bridging

· "Bridging services between institutions, and institutions and the community are vital to decreasing recidivism and the gaps in service provision to women offenders" (p. 9). Bridging is a particularly important concept in serving women with special needs, and deserves special attention, as they have a particular difficulty in making the transition between one environment and another because of their need for consistent and trusting relationships.

9. Staff Training/Education

· "Ongoing staff training and education in the mental health problems faced by incarcerated women is essential to creating an atmosphere of understanding and acceptance for this population and enhancing staff confidence and skills. However, only staff who possess a strong desire to work with women with mental health needs should be recruited" (p. 11). These special programs require distinctive approaches and demand that a high priority be placed: (1) on recruiting staff with a particular interest in working with women with the specific constellation of needs, (2) on training and supporting staff over time to utilize program-specific approaches, and (3) on supporting staff given the high demands that will be placed on them by the women.

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IV. Psychosocial Rehabilitation (PSR) Program Model For Women with Basic Skill Needs and Cognitive Challenges

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Conceptual Background of Psychosocial Rehabilitation

Psychosocial rehabilitation has its conceptual roots in a response to the failure of the mental health system to assist disabled clients in coping with the psychosocial devastation brought on by severe mental or emotional illness, severe behavioural problems and its traditional treatment methods (i.e., institutionalization and medication; Nel, 1994). Medicine traditionally views recovery as the process that follows the curing of an illness (frequently defined in relation to the prescription of medication), yet given the life experiences of these clients, recovery does not occur spontaneously once they are "treated". Instead, their recovery and successful return to the community is halted by...

- their limited resources, skills, and supports,
- their isolation, sense of hopelessness and despair brought on by institutionalization,
- their deviant behaviour patterns learned through institutionalization,
- their loss of community learning opportunities and supports that accompanied institutionalization.

These characteristics result over time in individuals developing chronic impairments which are seen as pathological functioning of a physiological or psychological nature (Anthony, 1990; Nel, 1994). The resulting dysfunction in turn limits the person's ability to fulfill normal social roles and function independently in the community. Individuals redefine institutionalization as "normal" and exhibit a sense of hopelessness with respect to recovery. Women with basic skill needs and cognitive challenges in federal penitentiaries have similar characteristics, backgrounds, and histories of institutionalization.

The psychosocial rehabilitation approach to recovery is based on (1) the experiences and voices of consumers demanding participation and self-determination in treatment, (2) the recognition that core values such as hope, empowerment, and determination are essential to recovery, and (3) the importance of targeted skill development and specific environmental supports as means to overcome impairments and enable individuals to function effectively in normal social roles and community settings. Rehabilitation and recovery require all three of these characteristics. Moreover, "recovery is what people with disabilities do... rehabilitation (is) what helpers do to facilitate recovery" (Anthony, 1993).

Psychosocial rehabilitation brought together three applied programming models in the 1980s and has now evolved and expanded to become the most prominent conceptual approach in North America to working with persons with severe emotional disabilities and impairments. One major approach is "psychiatric rehabilitation," a model developed at Boston University by William Anthony, his colleagues, and consumers (Anthony, Cohen & Farkas, 1990). Clients work through a individualized rehabilitation process with key staff which is grounded in self-determination, core values, skills-teaching, and environmental support in order to overcome impairments. This specific process has been developed and elaborated for a Canadian context at the Brockville Psychiatric Hospital which now provides national training programs in the approach (Nel, 1994).

A second psychosocial rehabilitation approach, labeled the "clubhouse model," evolved from the development of Fountain House in New York City in the 1960s (Beard, Propst, & Malamud, 1982). It is a group-oriented model that emphasizes work as a means to provide respect and meaningful activity. Service to others and peer support are viewed as critical elements of the recovery process. Clients initially work with staff to provide practical services to their peers and eventually to the community on a paid basis. This model has been applied to work with persons with emotional disabilities who have suffered from institutionalization with significant success in a vast range of settings and communities across North America (Anthony and Blanch, 1987).

A third major psychosocial approach has been labeled "assertive community living" and involves the development of a psychosocial rehabilitation plan and provision of resources to support individuals to move from institutional to community living situations (Stein & Test, 1986). It departs from previous mental health models in that a community team of professionals accepts responsibility to work collaboratively with the client to provide whatever skills training and environmental support is necessary (e.g., up to twenty four hour home care) to maintain the person in the community.

Elements of these three approaches are combined in this program proposal. It is recommended that the psychiatric rehabilitation core values and technology be utilized to guide the individualized planning and treatment process, that the work and meaningful activity focus of the clubhouse model be utilized to give women the opportunity to develop positive self-esteem and productive social roles, and that concepts from the assertive community living model be utilized to guide the transfer and integration of the women back into the community at the end of their sentences.

Women's Needs and the Applicability of Psychosocial Rehabilitation

Women with basic skill needs and cognitive challenges as identified in part II have significant deficits in life skills plus deviant behaviours such that they have not been able to function in the community nor in the group living environment of the regional facilities. They have experienced lengthy periods of institutionalization in psychiatric hospitals or penitentiaries. When they are released to the community, their sense of despair, skill deficiencies, and lack of supports and resources are such that they re-offend and return to an institutional environment which is familiar and which will care for them. Their lack of basic skills and need for guidance is often viewed initially with sympathy from other women when they are in regular housing in the regional facilities, but this sympathy turns to irritation and anger when women offenders, already under high levels of personal stress, must cope with their skill deficits and behavioural difficulties on a twenty-four hour basis. These women become stigmatized, manipulated and ostracized by at least some of the offenders, patterns that they have typically already experienced in the community or previous institutions. They may respond by acting out their behavioural difficulties such that they can not be maintained in the regular houses and are transferred to maximum-security settings with increased structure and supervision, even though they do not require increased security and are not a high risk given appropriate structure and support. Given these histories and needs, these women will require support on a long-term basis upon release by professional care-givers if they are to successfully maintain themselves in the community, though hopefully it would be in decreasing amounts over time as their confidence and skills increase. The following strengths are frequently present for these women and must be acknowledged in the program model:

- *Specific Likes & Dislikes for Practical Tasks.* Individuals often have very particular tasks and skills that they like to perform along with those they dislike or fear. Thus one woman may enjoy cleaning while another is very content quilting, but the former may refuse to cook and the other clean. Programming must build on their strengths and teach skills on an individual basis.

- *Moods and Mental State Reactivity to the Activity and the Environment.* Individuals are very changeable and strongly influenced by their immediate environment. Support, consistency, and a sense of security facilitate positive behaviour while stress in the environment or difficulty with the activity result in acting out and inability to cope.

- *Positive Attention and Trusting Relationships are Strong Motivators.* These women are typically pro-social in that they want attention from those around them and will work to receive it. They have difficulty forming trusting relationships given past experiences, yet once they do, these relationships can become a key means to facilitate change and recovery.

- *Confidence and Satisfaction Increase through Learning Practical Skills.* Individuals learn and gain skills slowly through task-oriented instruction and repetitive practice. They value and benefit from one-to-one attention through an individualized teaching process that personalizes their successes.

- *Criminogenic Attitudes are Less Dominant and Open to Modification.* Individuals have ended up in the correctional system due to their inability to cope in the community, their skill deficits, lack of supports and resources, and emotional disabilities, relative to anti-social attitudes and lifestyles. Where they have developed these attitudes, their desire for positive attention can be used to move to a more pro-social perspective.

- *Music, Art and Creative Expression are Valued Methods of Communication.* Many of these individuals have a particular affinity and strength for communication through the creative arts.

The following limitations frequently apply to women with this constellation of needs and must be recognized within the program model:

- *Sense of Hopelessness and Powerlessness.* Their past failures and inability to function in community settings combine with their experience of dependence and lack of choice in institutional settings to result in individuals losing hope for a different future. Instead they find comfort in others caring for them. This hopelessness must be overcome if the person is to grow and learn. It requires skilled staff and a living environment with practical choices for offenders. Hopeful core values must be intrinsic to all activities and must be modeled and lived by staff. The person's past successes, however limited, must be explored to identify potential for success in specific community settings in the future.

- *Past Failure and Low Self-Confidence Are Obstacles to Learning and Growth.* New tasks and environments are associated with failure and thus learning programs and change must be based on slow, small incremental steps and personal successes.

- *Reactivity to High Stress Environments.* Individuals tend to react quickly and impulsively to stressful situations and settings with difficult behaviours. They require a program and physical structure that can limit stress and provide security in a crisis.

- *Peer Relationships Produce Stress Given Poor Relationship Skills.* Connection to others is very important yet their weak relationship and problem-solving skills result in interpersonal conflict and a stressful environment in which they are unable to cope. Even medium sized groups (6-8 persons) increase the interpersonal confusion and potential for conflict. Skills need to be taught on an individual basis.

- *Poor Responsiveness to Group Programs Unless Individual Assistance is Provided.* Their unique needs and fears about learning new tasks require one-to-one attention. They have difficulty attending to and processing information in groups.

- *Cognitive Challenges and Limited Attention Span.* Programs must recognize these limitations by taking a holistic individualized approach and providing for informal interaction in a flexible manner.

- *Difficulty in Transferring Skills to New Environments.* A person may learn and demonstrate a skill in one environment but must re-learn it when moving to another environment. As the result, it is far preferable to teach skills in the environment in which they will be utilized. This is very problematic given that the priority is to prepare the women for community settings, yet the teaching may have to take place within a penitentiary.

- *Difficulty in Developing Trusting Relationships.* It takes time, and individuals may have great difficulty developing the trusting relationships that are essential to their independent functioning and success. They have difficulty making the transition to new environments because they lose their previous relationships and are confronted with their fears given past failures. It becomes imperative that trusting relationships support them through the transition to a new environment, be it the regional facility or a community setting, if they are to make a successful adjustment. Strong practitioner values and interpersonal skills are essential to developing trusting relationships.

- *Long-Term Community Supports are Required for Successful Re-Integration.* Community supports are required on a long term basis and yet the history of institutionalization and behaviour difficulties have resulted in individuals having few, if any, support persons. Human service systems typically do not provide for long-term supports and seek to withdraw services with time. These individuals act out in the community if supports are withdrawn.

A psychosocial rehabilitation model is the most appropriate approach to working with these women and has significant research to demonstrate its effectiveness (Anthony, 1990). However, this approach must be adapted in that these women can be distinguished from other persons with severe emotional disabilities given that their skill deficits and behavioural difficulties have resulted in their coming in conflict with the law while other persons with similar characteristics have not. Long term institutionalization within a prison has exposed them to and taught them a different set of behaviours than what they would learn in other facilities.

A common PSR conceptual model is also essential for the multi-disciplinary staff team and the administration in that it will provide a clear program structure and framework to fall back upon when they confront the complex interconnections in working with women with these needs and difficulties. These women offenders are very demanding and staff require on-going support from each other, a strong team, and administrative support to maintain the hopeful core values and the detailed skill development and planning that are required for success.

Program Purpose and Objectives

⬆

The ***purpose*** of the psychosocial rehabilitation (PSR) program is to support women offenders with basic skill needs, cognitive challenges, and behavioural difficulties to live successfully in regional penitentiary facilities while gaining skills which will enable them to experience greater satisfaction and success in a supported community setting upon release, reducing the likelihood of recidivism.

Objectives. By participating in the psychosocial rehabilitation (PSR) program, women offenders with basic skill needs and cognitive challenges will...

- increase their basic life skills in areas of need.
- function in a regional facility without persistent acting out difficulties.
- establish and follow through on a community correctional plan for release that will reduce the likelihood of recidivism.
- demonstrate increased self-esteem.
- express satisfaction with their living environment relative to their previous experiences.

Finding: The psychosocial rehabilitation approach is the most appropriate and potentially effective programming model for individuals with basic skill needs and cognitive challenges such that they can reside in the least restrictive environment in a regional facility. The approach must be adapted to the regional penitentiary setting by staff trained in the psychosocial rehabilitation approach. A disproportionate number of women in Canadian penitentiaries with basic skill needs and cognitive challenges come from Atlantic Canada.

Recommendation 1: Implement the psychosocial rehabilitation

> challenges through a specific program model appropriate for the regional facilities, which incorporates relevant elements of psychiatric rehabilitation, the clubhouse model, and assertive community living. This model shall reflect the specific strengths and limitations of the women with this constellation of needs and be based on a specific purpose and set of objectives. The psychosocial rehabilitation program model should initially be implemented as a pilot project at Nova Institution in Truro, Nova Scotia.

Admission Criteria and Assessment Process

The following criteria are required for admission to this program:

1. *Voluntary agreement by the individual woman to participate.* It must be recognized that women with these needs are extremely changeable in their willingness to participate in any setting or set of activities and therefore their agreement should be developed over time through a trusting relationship in which they are encouraged to take time to understand their choices. They must also understand that there would not likely be other living accommodations available to them at a regional facility, as they could not cope without supervision in a regular house. The withdrawal of consent should also require time and working through a discussion process with a trusted person.

2. *A medium- or minimum-security classification.*

3. *Recommendation for participation by the multi-disciplinary assessment team* at the regional facility responsible for assessment for specialized mental health programs. This team will utilize existing mental health and risk assessments, and gather additional information or complete additional assessments as required to assure that the individual meets the following criteria:

   a. Significant deficits and needs in more than one of the following life skill areas:

   - self-care (e.g., personal hygiene and appearance, personal health care, sex education, organization of time, etc.)

   - household tasks (e.g., meal preparation, cleaning, laundry, budgeting, etc.)

   - basic communication skills (e.g., social manners, assertiveness, appropriate social interaction, problem-solving in relationships, etc.)

   - basic coping skills (e.g., stress management, anger management, basic problem solving, appropriate ways to seek help, etc.)

   - basic work skills (e.g., attention span and task completion, reliability, performance to standards, etc.)

- leisure skills (e.g., ability to manage leisure time, practical skill development, etc.)

b. Significant learning and cognitive challenges such that skill development requires an individualized or small group learning environment.

c. Requirement for on-going support and supervision by staff in the living environment to solve problems, cope with peer relationships, and/or manage inappropriate behaviours.

The multi-disciplinary team responsible for assessment for specialized mental health programs will include the following positions and/or disciplines:

· psychologist

· coordinator of the psychosocial rehabilitation program

· registered nurse with psychiatric training and/or experience

· occupational therapist

· community integration worker

· warden and/or deputy warden

· intake case management officer

· team leader or director of programs

· coordinator of the dialectical behaviour therapy program (if existing at the facility)

The assessment process must include a formal cognitive assessment by the psychologist if it has not already been completed. It is expected that criteria 3b above will result in intellectual functioning in the low normal, borderline, or challenged ranges. The assessment process should also include a basic life-skills assessment by the occupational therapist if it has not already been completed so as to address skill needs outlined under criteria 3a above. The coordinator of the psychosocial program must meet with the woman to educate her about the program and consider behaviour issues and personal suitability for the specific group of women with whom she would be living. The psychologist should be the chairperson for the multi-disciplinary admission team and every effort should be made to make program recommendations based on a team consensus. This process should be facilitated within a two-week time frame if the individual has come directly from the court system.

Throughout the interview process for this research, staff identified the greatest threat to the implementation of an effective program as the possibility that the admission criteria would be circumvented due to national or regional operational pressures to move an inappropriate offender into the program, simply because the woman required a higher level of supervision in the regional facility. The mix of incompatible women with very diverse needs and skills was viewed as the most important reason for the failure of the previous structured living house at Nova Institution. The staff at Nova Institution expressed very strong feelings that this mistake not be repeated. It is imperative that the final approved program is defined in writing with formal, written admission criteria and a clearly defined decision-making process for admission.

Finding: Matching the needs of individuals with the program goals and structure is essential to success. Inappropriate mixes of women offenders will compromise the effectiveness of the program and represent a major threat to its effectiveness. This is a particular problem given the potential for operational pressure to place inappropriate women in the program simply as a result of their needing higher levels of supervision.

Recommendation 2: A formal written, multi-disciplinary assessment process with admission criteria based on the consent of the woman offender, a medium or minimum security classification, significant basic skill needs, significant cognitive challenges, and the need for staff supervision, is required for entry into the program. There must be an official, approved program description with clear admission criteria which requires staff at the regional facility to make the final decision on admission.

Psychosocial Rehabilitation (PSR) Planning

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Psychosocial rehabilitation planning is based on a set of core values, basic principles, and a three phase planning process including eight major areas for work with clients (see Appendix B; Nel, 1994). The four core values are that the approach be: (1) client-driven, (2) non-judgmental, (3) hopeful, (4) and empowering. The ten principles that guide the approach are:

1. *Logical Technology.* Work with the individual begins with the client's dissatisfaction with present circumstances, and the need for change motivates a series of logical planning steps.

2. *Concrete Concepts.* Concepts are concrete, observable and measurable.

3. *Individualization.* Rehabilitation work is tailored to each client.

4. *Goal-Driven Process.* The client's goals drive the rehabilitation work.

5. *Satisfaction versus Success.* Both the client's desires (which dictate satisfaction) and the environment's expectations (which dictate success) have to be considered.

6. *Support versus Skill Development.* Dysfunction can be diminished by enhancing skills and/or increasing supports, and there is an interdependence between them.

7. *Skill and Support Development are Environment and Role Specific.* Dysfunction is addressed at a very specific level and skills and supports are facilitated for the specific goal environment.

8. *Accountability.* Rehabilitation plans are written, with time frames and specific people responsible for specific tasks. The client is the owner of the plan and the practitioner is accountable to the client.

9. *Client/Practitioner Relationship.* Rehabilitation work is a partnership between client and practitioner. Personal closeness and trust is required to sustain the long and often arduous work.

10. *Sound Interpersonal Skills (of the practitioners).* Rehabilitation technology is information-processing technology which can only be helpful if the practitioner has the interpersonal skills to establish and maintain a trusting relationship through which information can be shared. (Nel, 1994, pp. 11-12):

The core values and basic principles define a process that is in keeping with the strengths and limitations of women offenders with basic skill needs and cognitive challenges. The approach provides an individualized, value-based, skill-based process that is driven by the goals set by the woman offender. The actual rehabilitation work is divided into three phases in which the practitioner works through eight modules with the woman offender. These modules are sequenced as follows:

PHASE ONE: Assessing the Rehabilitation Requirements

1. *Assessing and Overcoming Barriers to Commitment to Change.* Frequently, individuals immediately present barriers to developing a commitment to change such as: lack of self-awareness, lack of environmental awareness, lack of feeling of self-efficacy, lack of perceived support from others, and/or lack of trust in the practitioner. Specific action plans may need to be defined and implemented to overcome these barriers and lack of awareness before the person can articulate any need for change or consider setting goals.

2. *Establishing the Demand for Rehabilitation.* This step involves exploring the person's present dissatisfaction with living, learning, working, and socializing environments and the extent that the person hope's for, or visualizes change as an option for one or more of these environments.

3. *Establishing the Rehabilitation Goal and Choosing the Goal Environment.* The person explores the nature of the changes that would lead to greater satisfaction and success, and identifies the specific environment that will best support this change. Ultimately a goal is set to fulfill a specific role in a specific setting.

4. *Skill-Use Assessment.* This step explores and defines the specific skills the person will require to fulfill a work, living, socializing or

learning role in a specific setting as defined by the goal.

5. *Resource Assessment.* The task is to identify the types of resources and supports that the client requires to achieve satisfaction and success in the goal environment and to establish their availability.

PHASE TWO: Planning the Rehabilitation Interventions

6. *Writing the Rehabilitation Plan.* This represents the road map necessary to complete the rehabilitation interventions and achieve the goal in the specific environment.

PHASE THREE: The Rehabilitation Interventions

7. *Skill Development.* The process of skills-teaching is implemented in which skills are broken down into manageable steps and taught in a logical sequence, with lesson plans and extensive feedback.

8. *Resource Service Coordination.* Strategies are implemented to overcome the resource deficits required to support the individual. This may require advocacy and negotiation to: make existing resources accessible to the individual, to coordinate existing resources in new ways, or to create new resources. (Nel, 1994, pp. 13-17)

This specific psychosocial rehabilitation technology differs from many traditional mental health program-planning approaches in several very important ways:

· Skills are not assessed or taught until after the individual defines the change (goal) they are seeking. Therefore the goal motivates skills-teaching rather than a person participating in "programs" to teach them skills that others think they need. Skills-teaching and resource development are individualized. Work to increase awareness and overcome barriers to change will precede goal setting.

· Goals are not set in a session or two but rather through an on-going individual relationship between the practitioner and the woman, which is structured through a lengthy assessment process. The difficulty in helping these women gain a sense of hope and overcome their barriers to change is acknowledged and built into the process. This requires a skilled practitioner.

· Core values of hope and empowerment are deliberately built into all of the assessment processes that are utilized such that working through the specific tasks structures the process as client-driven.

· Goals, skills, resources, and plans are structured around the specific role and environment that the individual chooses. The process is carried through separately for living, learning, working, and socializing environments and roles. The living role would typically be the first priority for these women.

The implementation of this approach in the proposed program requires:

1. A core group of staff committed to this process who each works with individual women on a consistent and regular basis. Relationship building and rehabilitation work is an on-going formal, as well as an informal process, which requires extensive interaction.

2. Staff explicitly trained in the approach who are competent to apply it with women offenders.

3. The psychosocial rehabilitation plan must be integrated into and become the correctional plan for release.

Finding: The psychosocial rehabilitation planning technology incorporates some traditional mental health planning approaches such as careful assessment and structured skills-teaching for women offenders with basic skill needs and cognitive challenges. It differs from traditional approaches in several important ways: goal setting precedes skills-teaching, emphasis on the need to overcome barriers in order to commit to change, explicit core values, and an explicit client-driven technology.
Recommendation 3: The individual programming with women with basic skill needs and cognitive challenges should be driven by the psychosocial rehabilitation technology process in which staff practitioners competent in the approach develop partnerships with the women offenders on an individual basis. Supportive relationships between the women offenders and a consistent and small number of staff is required to support this process.

Characteristics of the Physical Living Environment

Women offenders with these needs require a small group living environment with regular staff presence in order to minimize stress and allow for the time and space to implement the psychosocial rehabilitation process. It is proposed that it take the form of a one-story duplex, with each side serving up to four women. It should be built...

- to mirror the appearance of a house in a community context,

- to minimize dangerous objects in the environment in the event of acting-out behaviour,

- to provide security in the event of acting-out behaviour,

- to provide residents with a continuum of options and locales through which they can take greater or lessor responsibility, depending on the circumstances, for coping with stress and potentially explosive or self-destructive behaviour.

Careful planning involving architects, staff (including front-line staff and the PSR program coordinator), and women offenders, is required to simultaneously maintain a home-like appearance while minimizing dangerous objects and providing security for emergencies. Architects must take practical direction from experienced staff in defining the detailed elements of the duplex (e.g., types of lights, size of halls, ability to lock various areas, etc.) The program coordinator must be hired as soon as possible and should be responsible for gathering and facilitating staff and offender input into the design. With respect to the offenders, gathering input should include the coordinator visiting women in maximum-security facilities who are potential candidates for the duplex, explaining future placement possibilities, and seeking their input on the design.

Figure 2 presents a draft proposal for the duplex design which implements the following criteria:

· A maximum of four clients per side in order to maintain a small group size while providing for adjacent dwellings so that staff can be shared. The two separate sides provide for flexibility in separating incompatible women. Although four persons per side is a small number, it must be recognized that increasing the size of the group results in an exponential increase in problems due to all of the new relationships which are introduced, rather than simply adding one additional person.

· A home appearance which is attractive and bright and allows for women to decorate walls, have comfortable furnishings, and include plants. The interior design should facilitate women being able to make choices on the appearance of their home while decisions by one set of women can be altered by a later set (e.g., use of bulletin boards or picture frames in which images can be shifted). Music should be encouraged in the setting through the provision of a modest electric keyboard to accompany singing.

· Multiple quiet and separate spaces for women should be available while maintaining reasonable ability for staff to monitor the setting.

· Facilities for therapeutic quiet (see below) should be available and buffered by staff space. They may be used for a woman at the discretion of the woman offender or as required by staff policies and procedures. An immediate bathroom facility should be available in the therapeutic quiet area so that a woman does not have to return to the main living environment.

· Two small bathrooms for residents should be provided in case there are hygiene difficulties or teaching needs such that one woman requires her own bathroom.

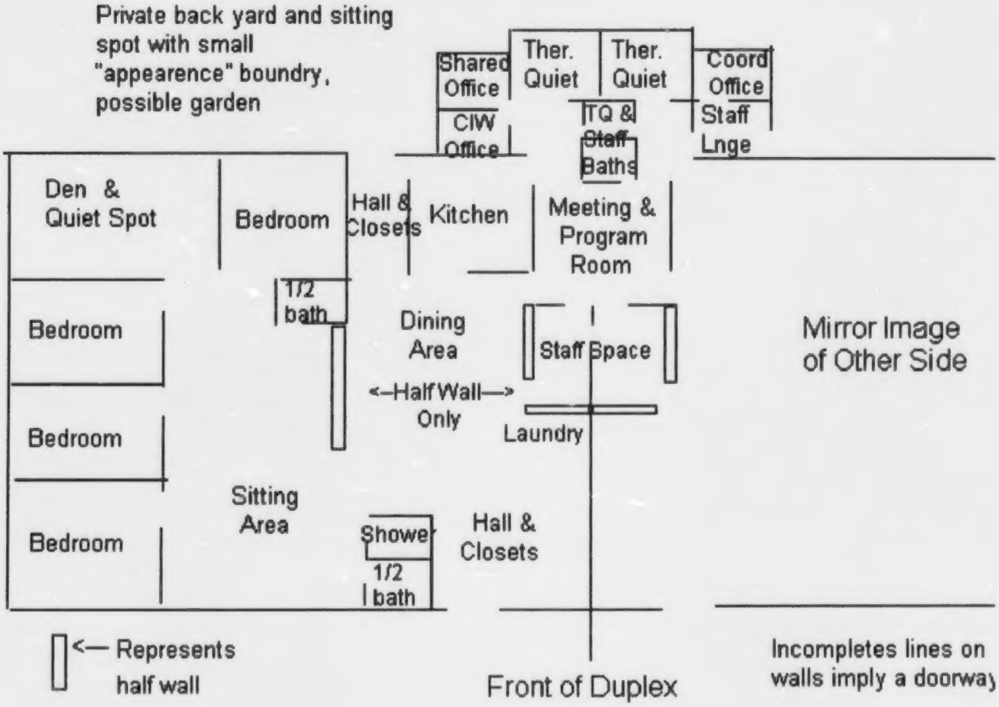
· High quality sound insulation is required between the two sides of the duplex, between the bedrooms, and insulating the Den/Quiet Spot, so as to reduce the possibility of one person upsetting another. The quiet spot must be an attractive, peaceful, and relaxing room with good natural light.

· Ability to lock down bedrooms in an instance where one woman is acting out and other women need to be separated from the situation.

· A full kitchen should be available for preparing all meals and should open on to the rest of the house, yet be able to be locked when necessary (e.g., double doors might close it off).

· A dining area with a table for meals should be adjacent to the kitchen.

Figure 2: Proposed Floor Plan for the PSR Duplex


Private back yard and sitting spot with small "appearence" boundry, possible garden
Shared Office
CIW Office
Ther. Quiet
Ther. Quiet
TQ & Staff Baths
Coord Office
Staff Lnge
Den & Quiet Spot
Bedroom
Hall & Closets
Kitchen
Meeting & Program Room
1/2 bath
Bedroom
Dining Area
Staff Space
Mirror Image of Other Side
<--Half Wall--> Only
Laundry
Bedroom
Sitting Area
Bedroom
Showe
1/2 bath
Hall & Closets
<— Represents half wall
Front of Duplex
Incompletes lines on walls imply a doorwa

· Each side should have a backyard where women can establish their own sitting area and possibly a garden distinct from the broader compound. This area need not be fenced for isolation, but can be bordered for privacy.

· Small offices should be provided for the coordinator and the community integration worker (CIW, see below) as well as a shared office to be used by PSR workers and clinical staff in the duplex so that staff roles are integral to the setting and maximize interaction with the women and staff. There should be an outside door into the staff lounge so that staff can come and go from the setting without having to move through the duplex.

· The staff space should be divided by the main wall separating the sides of the duplex with a solid door in between the sections to maintain each setting as a separate living environment, while allowing staff to move quickly back and forth when needed. The staff space should integrate as openly as possible into the living environment on each side utilizing half walls. Items which must be maintained under lock and key could be kept in a locked closet or drawer in the staff area, or stored in one of the offices. This open plan for the staff space makes staff presence integral to the environment and encourages staff accessibility to and interaction with the women. In addition, staff are provided with their own bathroom and a small lounge so as to encourage breaks within the setting.

· A multi-purpose meeting and program room. It can be used for individualized programming or as a meeting room for staff so that meetings can occur within the setting, allowing PSR workers to attend meetings while also providing staff supervision. It should have a movable room divider to separate the two halves.

· The front and back doors should have an attached buzzer system which would warn staff of women leaving and entering the building if it is activated.

Finding: It is important to provide women with basic skill needs and cognitive challenges with a small group living environment which simultaneously provides a home-like appearance that mirrors community standards, while also insuring safety and security in instances of acting-out behaviour. Staff expertise and input from women offenders is required to balance these design criteria.

Recommendation 4: Plan and construct a duplex house with up to four women living on each side at the regional facility utilizing the proposed structure and criteria as a starting point for planning. The architects must utilize staff expertise, and input from relevant women offenders, to plan the house. The program coordinator must be hired as soon as possible such that the coordinator is able to facilitate staff and woman offender input into the design. A committee made up of the lead architect, the builder, the warden, and the PSR coordinator must have the final authority on all phases of the design and construction process.

Daily Living Expectations and Skills-Teaching in the PSR Duplex

Daily living tasks such as cooking, cleaning, laundry, and budgeting should be the responsibility of the women offenders but should be completed in partnership with staff members as is appropriate to the skill level and educational needs of the women. It is expected that since skill deficits are a criterion for admission to the program, that staff will play an important facilitation role with respect to the women working on these tasks. As individual women gain skills, staff roles may be reduced such that increased responsibility is transferred to the women. The women should be provided with as many options for input and choice as is possible in carrying out their daily tasks (e.g., menu choices, options with respect to cleaning tasks, etc.). Provision must be made for funds for food for staff members within the meal budget so that staff may eat with the women without reducing the women's resources. It is ineffective and distancing if staff are partners and facilitators of the meal preparation process and yet feel awkward eating the food due to imposing a drain on the budget.

The roles, responsibilities, and supports for individual women with respect to daily living skills must be connected to their psychosocial rehabilitation plans, either with respect to the second PSR module in which they are overcoming barriers to change and gaining awareness of living situation possibilities, or in the skills-teaching module once a goal has been set for their future living environment. The occupational therapist will assist staff in planning and carrying out work with women on daily life skills. The practical experiences of completing the daily tasks should be the primary mechanism for teaching skills and may be deliberately structured as a learning process for women with particular needs. Interpersonal relationships and social interactions in the house will also provide practical opportunities through which to teach positive communication, coping, and problem solving skills at a basic level. These experiences and the teaching process will be connected to the individuals' rehabilitation plans for the living and socializing environments. The psychologist and occupational therapist will assist staff with programming work with the women in these areas.

The amount of structure in daily schedules for individual women will vary with the abilities of the women based on their individual rehabilitation plans, but choice will be maximized within the boundaries of the individual being able to make safe choices for themselves and others. Again, given significant skill deficits, schedules may need to be structured at the outset.

Informal interaction and leisure opportunities between individual women, and between individuals and staff, are an important priority and means to develop the trusting relationships which are required for psychosocial rehabilitation work. Staff in the house will be expected to participate in and facilitate, to the extent necessary, positive leisure interactions.

Finding: The living environment is an important context in which these women can learn basic skills and take on practical responsibilities, but they will require assistance and support from staff to do so. Learning is most effective when it is a deliberate, structured part of carrying out daily living tasks with extensive feedback built into the process. Interpersonal communication difficulties will be an ongoing issue and a valuable forum through which to learn problem-solving skills.
Recommendation 5: Staff should plan skills training in order to take advantage of daily activities which are completed as a part of the regular lifestyle as teaching opportunities. Interpersonal communication and relationships should also be utilized as a context for teaching social skills. Skills-teaching action plans should be based on the psychosocial rehabilitation plan. Daily structured meetings should be held to facilitate management of daily tasks, interactions and responsibilities in the home.

Work, Learning, and Leisure Programs and Skills

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The individual's psychosocial rehabilitation plans will determine participation in work, learning, and leisure programs and therefore it is impossible to determine exactly what learning experiences will be provided. However, a number of general guidelines can be suggested given the overall assessment of the needs of these women based on interviews with them and staff.

· *Integration into Regular Programming versus Specialized Programs.* Participation in core correctional programs and educational programming with the general population is to be encouraged as long as it is beneficial to the individual woman and connected to the PSR plan. Typically, these women require a volunteer or peer support person to assist them in participation in regular programs. In at least some instances the PSR plan is likely to involve individualized programs or small group programming within the setting because the material is not offered in the regular program or the format is too complex for the particular women. This individualized or small group work will require careful planning and expertise from disciplines such as occupational therapy, psychology, and nursing. Staff in the programming section at the Prison for Women have put together a wide range of resource materials and simple programs for the women on their special needs unit which could be very valuable to planning and programming efforts in this program.

· *Emphasis on Creative Arts and Self-Awareness Activities.* Self-awareness is important for these women and many have an affinity for music and art. These programs may best be offered in small groups or on an individualized basis and staffing must be included in the program staff complement. The women should also be encouraged to participate in the broader leisure programs offered at the institution as is appropriate.

· *Developing a Sense of Ownership in the Setting.* Pride and a sense of belonging to the duplex are important for these women to gain confidence and a sense of self-efficacy. They have traditionally lived in settings where they have not had any control over their surroundings. Staff should facilitate projects in partnership with the women which assist them in developing a stake in the setting while engaging in meaningful activity (e.g. creating a garden, improving the internal appearance of the house, putting on small social events for other members of the community or for special events). Staff training in "clubhouse" approaches to working with disabled populations would be extremely helpful in providing a philosophical foundation for this work. There should be structured daily meetings of the small group of people living together in order to discuss and negotiate their practical daily concerns.

· *Promoting Self-Esteem and Personal Accomplishment through Work and Service Projects.* Work projects will likely be an important element of PSR plans and should be defined as a result of them. Service may be in the form of projects which build a sense of pride in the living setting (developing a garden). In general, work and service should be emphasized in the context of the clubhouse philosophy in which work projects:

> · are visible and valued by other persons in the duplex and/or the broader penitentiary community.
>
> · are clear, structured, and manageable for the individual with evident accomplishments.
>
> · provide frequent opportunities for immediate success and demonstrated progress.
>
> · are valued in the broader community (e.g. selling items or services outside of the penitentiary).
>
> · can be varied over time to allow for awareness of a diversity of

tasks.

Traditionally cleaning has been a common work task in penitentiaries yet it may not necessarily meet these criteria, especially when it occurs in less visible areas. Individuals may not receive recognition for it and there is neither a highly visible result nor an opportunity for feedback. In contrast, more suitable tasks might involve the production of crafts which can be used, displayed and/or sold in the community (e.g., knitting clothes for a child of another inmate, cooking food for events, etc.). Special care should go into defining work placements based on the individual's PSR plan, their strengths and limitations, and the specific rewards inherent in the particular work role. The occupational therapist should assist in program development in this area and staff training in "clubhouse" approaches is required.

A limited amount of work area may be required in the general programming area of the institution where project work can be completed and stored. Nova has very limited space in its programming area and must examine how best to provide for this space.

Finding: These women are typically fearful of new learning situations given their past histories of failure in community settings. On the other hand they often value meaningful, structured and practical tasks where they receive positive feedback and recognition. They have a particular affinity for art and music.

Recommendation 6: Deliberate individual and small group activities defined through each person's psychosocial rehabilitation plan should provide opportunities for integration into regular programs, specific work and service projects, participation in creative arts activities for self-expression and awareness, and the development of a sense of ownership in the living setting. A clubhouse philosophy should guide this programming so as to promote recognition through work and service and teach skills through practical experiences.

Behaviour Management in the Living Environment

The effective implementation of the psychosocial rehabilitation values, the investment of the women in the process, and the structure and support of the staffing and program should reduce behavioral difficulties over time. However, these women have long-term behavioural difficulties that will inevitably manifest themselves and they must be addressed effectively in a team context. Behavioural acting out is for these women most frequently a response to specific stresses and circumstances in their setting or unexpected changes in their lives combined with inadequate coping and problem-solving skills. For women with cognitive challenges, consequences must be immediate, concrete, direct, consistent, and based on natural contingencies. Specific approaches must be applied consistently across the staff team so that an individual knows what is expected in concrete terms.

There is a potential serious conflict between the emphasis on choice and empowerment which is fundamental to these women establishing hope, confidence, and a stake in their own lives, and behavioural programs and consequences that staff feel are required to manage difficult behaviours. Acting-out behaviours require consistency and actions that typically remove control from the individual women and reinforce dependency. If there is insufficient positive attention in the environment, negative consequences and the resulting attention can in fact reinforce behaviour for women who have received insufficient positive attention during long-term institutionalization. Moreover, if staff interactions with individual women are dominated by behavioral plans then it is difficult or impossible to develop genuine and trusting relationships with individual women. There is a very fine line between the need to take consistent action to manage behaviour and contravening key values of the psychosocial rehabilitation program. Several important elements are required to effectively walk this fine line:

House Expectations and Natural Consequences. Any group of people requires basic expectations in order to live together in a cooperative manner and these expectations need to be clearly defined by the women and staff in the setting at the outset. Failure to live up to these expectations should invoke natural consequences as opposed to "personal" consequences aimed at behavioral control of the individual. For example, others will not interact with a person who never bathes and therefore minimal hygiene would be an expectation of the house. A given woman may need skills-teaching, encouragement, and positive reinforcement for her hygiene efforts, but ultimately there may be a consequence for not meeting the hygiene expectation, e.g., the inability to eat with others. A "personal behaviour" consequence and a "natural" consequence may in some instances be very similar with respect to the actual result but the interpretation and process of developing them is different. In the first instance it is perceived as a staff response to control an individual's behaviour while in the latter instance it is an expectation set by all of the members of the setting (including staff) and implemented by staff as a part of their role in the setting.

Multi-Disciplinary Team Meetings and Communication. The development of balanced and consistent approaches to behavioural problems is a very difficult task requiring multiple perspectives and a high level of communication among staff. Formal multi-disciplinary team meetings should be held weekly to discuss the progress of the women in the program and to serve as a means to coordinate efforts and work on projects in smaller groupings. They should involve all of the key staff members in the program including the coordinator, psychologist, occupational therapist, nurse, community integration worker (see below), as many PSR workers as possible, and as many other staff as is possible who are relevant to the current work. Specific steps must be taken to structure the PSR worker's participation, and funds must be budgeted to allow for it. Scheduling options include:

- holding the meeting across the change of shift.
- providing compensatory time (to be used at a later point) for staff attending the meeting.
- meeting when the women are out of the house so that staff on shift can attend.

Careful Reflection on Staff Values, Interaction Styles, and PSR Values. It is imperative that staff reflect on their own values, psychosocial rehabilitation values, and their own behaviour and style of interaction as a means to considering specific responses to behavioural issues. Difficulties may be avoided in some instances if staff intervene in a preventative manner, while in other instances it may be important to ignore the situation, or to recognize that the behaviour may only be problematic for the staff rather than for the functioning of the individual or the safety of the setting. These decisions and strategies require team communication, a shared vision of the program, and a foundation in psychosocial rehabilitation and behaviour management. Staff training and team building are important elements in achieving success.

Continuum of Quiet Options. Another key element of behaviour management is working with individual women in order to improve their coping and problem-solving skills with respect to specific stresses. They require a continuum of options through which they can take steps to control their behaviour and/or ask for help from staff. There must be space to "get away" within the setting when they are under stress. The options should include:

- enabling their bedroom to be a relaxing spot through their ability to decorate and control its appearance, and by insulating it from sound from the rest of the setting.

- establishment of an outdoor quiet spot behind each side of the duplex where a woman can relax.

- provision of a den/quiet spot in the setting as an alternative refuge which is attractively furnished, well lighted, and insulated for sound.

- provision of therapeutic quiet, a safe room which can be locked and viewed by camera. A woman should be able to ask to enter therapeutic quiet for her own safety, or she may be placed there for her own safety by staff according to specific policies and procedures.

Recommendation 7: Staff must balance the need for hope and empowerment inherent in psychosocial rehabilitation with the need to cope with offenders' behavioural difficulties. Setting the appropriate balance should involve the use of group defined house expectations, natural contingencies, multi-disciplinary team meetings, staff reflection on values and interaction style, and a continuum of quiet options.

Therapeutic Quiet. Therapeutic quiet is an essential element of the duplex design and must be regulated by specific procedures developed for the setting. Women with cognitive challenges may lose control of their behaviour and/or act out such that they require short-term, externally locked control and clear consequences, be it for a few minutes or a few hours. However, lengthy isolation is counter-productive as the offender loses focus on why she is isolated and she may become more desperate, hopeless and dependent. Invoking segregation is often inappropriate for the circumstances and yet a brief therapeutic quiet option is required if it is to be avoided. Segregation always does exist as a last resort but one would not expect to use it, and if it was used with some frequency for an individual, staff would have to question the effectiveness of the program for this woman. The psychologist should work with the staff team in consultation with the institutional administration to define specific written procedures for the use of therapeutic quiet. The psychologist should consult with the programming team at the Prison for Women to draw on their expertise and experience with the use of therapeutic quiet with special needs women. For experienced correctional staff unfamiliar with the use of therapeutic quiet, there may be a perceived risk in using it in instances where the staff member might have formerly relied on segregation. It will be important to train and support staff to use therapeutic quiet.

Medical/Psychiatric Involvement and the Use of Medications. PRNs and specific medication regimes can be used to assist women in crisis and teach coping skills. In this instance, medication can represent a form of chemical restraint much as therapeutic quiet can represent a form of physical restraint. Both approaches have benefits, serious side effects, and the potential to limit a person's rights. Penitentiaries historically have normalized the benefits of physical restraint while downplaying the side effects and rights abuses, yet have frowned upon chemical restraint, in this instance pointing to the dangerous side effects and potential rights abuses. Significant medical/psychiatric and nursing involvement in the staff team is essential so as to weigh the potential benefits and dangers of medication usage and determine appropriate written procedures for its use. The nurse should be responsible for developing these written procedures in consultation with doctors, the staff team, and the administration. Provision should be made for the consulting doctor to participate in at least part of the weekly multi-disciplinary team meeting.

Recommendation 8: Therapeutic quiet must be an essential element of the duplex design through which women can learn to better manage stressful situations, and through which they can be secured when a danger to themselves. Specific written procedures must be developed to monitor its use. Staff must be trained in its use. Medication may also be a useful tool to assist women in stressful situations but its use requires stringent monitoring and written procedures.

Stigma Versus Peer Support and Teaching

Women with basic skill needs and cognitive challenges may be viewed by other offenders, and other members of the community, in a range of ways varying from disdain and rejection to solidarity. Frequently their experience has been one of isolation, rejection, and stigma. The previous structured living house at Nova suffered from the label of the "crazy house". In contrast, individual offenders often express a willingness to help these women if they do not have to co-exist with them twenty-four hours a day. If the women in the PSR program become severely stigmatized by others, they will reject the program for themselves and act out to disrupt it. Women with basic skill needs and cognitive challenges will inevitably be viewed as "different" as a function of their behaviour and their involvement in the program. However, stigma associated with these differences must be minimized or avoided. Several elements are essential to address the issue of stigma:

· *Peer Support and Teaching.* The most essential element is to provide opportunities for other offenders to work with women in the PSR program through voluntary, structured, one-to-one interaction and peer support, as a part of their regular activities. This process can break down the isolation of the women and allow other offenders to interact with them in a caring and productive manner which gives both individuals a sense of accomplishment. The women with basic skill needs become unique individuals who benefit from support and in turn can respond with caring. The peer-support offenders can become advocates with other offenders for the women in the PSR program who may have communication problems with them. The peer-support offenders benefit from the satisfaction of helping others and the individual women benefit from the one-to-one attention they require to participate in programs or learn skills.

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Peer Education. Other woman offenders should be educated about the nature of the PSR program and the needs of the women involved in it from the vary outset of their time at the institution. The need to mobilize peer-support workers can become a basis through which to initiate the education process and it should be carried out on an on-going basis through the regular offender orientation program. The peer-support workers should play a key role in educating new offenders through the orientation sessions.

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Peer-Support Training. Program staff must work with the inmate committee to design and deliver a training package for offenders who volunteer to work with the women with basic skill needs and cognitive challenges. It is important that they have an understanding of the difficulties these women face, their skill needs, the psychosocial rehabilitation approach, and effective ways to work with them.

· *Sense of Ownership and Attractiveness of the Living Setting.* The women who are potential candidates must be involved in the design of their setting from the very outset and staff should facilitate their efforts to decorate and improve the setting from the moment they arrive. The duplex design is such that it will have attractive features relative to the other houses (e.g., smaller group living, a den/quiet room, a private outdoor space, etc.) such that the individuals will see practical benefits in their living accommodations. These elements must be emphasized and staff must work to encourage a sense of ownership in the setting among women along with providing education to promote self-awareness of why this setting is suited to their needs.

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Integration into Regular Programs. The women in the PSR program should have opportunities to participate in regular programs and leisure programs as long as it is beneficial to their interests. Staff must be particularly cognizant to avoid standard security procedures for women in the program such as requiring escorts which would drastically limit their ability to integrate into regular programs due to a lack of staff resources. Creative alternatives developed through the multi-disciplinary team should be utilized when some monitoring is essential, e.g., use of peer support, volunteers, communication with staff in the programming area, etc.

Adherence to the Admission Criteria. Departure from the admission criteria and inclusion of women who are functioning at a higher cognitive level or do not have evident basic skill needs will blur the perception of the house as a positive education program and emphasize it as a setting for those who act out.

Recommendation 9: Stigmatization and labeling of these women offenders poses a serious threat to the success of the program and should be minimized or avoided through: a peer support program, peer education, facilitation of a sense of ownership in their home, adherence to the admission criteria, and their integration into regular programs.

Bridging for Community Integration

Women with basic skill needs and cognitive challenges will require on-going support in the community in one form or another for the rest of their lives. It is imperative to recognize that if the correctional system does not either provide this support or ensure that others do, it will inevitably fall back on the correctional system to maintain these women in a penitentiary, which is expensive and detrimental to the women, and to the society as the result of the additional offenses they would commit. Moreover, based on staff and inmate interviews, and the research of others (Kendall, 1995), the existing correctional plan and release process has serious problems for women in the general population, particularly with respect to the lack of bridging, communication, and involvement between the penitentiary and community resources, be they within or outside the correctional system. This process is even more problematic for women with basic skill needs and cognitive challenges because they have much greater difficulty adjusting to new settings and relationships and transferring their skills and relationships across settings. Transitions must be slow and supported by stable relationships to be successful. The present relatively impersonal community release process of handing a person to new correctional staff and support persons across jurisdictions is a recipe for recidivism for these women. An alternative model is required based on the "assertive community living approach" conceptualized and implemented by Stein & Test (1985).

The key community integration worker must be based in the institutional program such that the foremost priority is to build a strong relationship with each individual woman to assist her in moving to the community. It is not possible to develop this type of relationship with these women if the worker is based in the community and can only come to the institution periodically. However, it is possible for an institution based worker, who has a strong relationship with the individual offender, to go to her home community and develop effective relationships with community support organizations and workers so as to facilitate the transition.

Community Integration Worker. A specific staff role and process is proposed for the PSR program which has the primary purpose of providing the bridge between the work in the penitentiary with the woman and the support system to be provided for the woman upon release in the community. The key elements of the "community integration worker" role are:

- to develop a trusting relationship on an individual basis with the offenders through informal and formal interaction.
- to participate in the psychosocial rehabilitation planning process for the woman developed through the woman's partnership with her PSR worker. The goal environment for the individual's living situation must be based on the individual's personal criteria. Extensive effort must be placed on discovering what worked and did not work in the past along with the assessment results of what the person can and can not do at present.
- to contribute to the action plans, skills-teaching, and individualized programming with each woman as is appropriate.
- to establish contacts and visit the release community to advocate for, negotiate, coordinate, and create support systems for release, in partnership with the woman based on her PSR plan.
- to provide training and education to persons and organizations who will provide community supports upon release with respect to the needs, goals, and experiences of the individual woman.
- to assume primary responsibility for case management functions once the individual enters the PSR program.
- to accompany the individual upon release and to support her in the community living situation for a transition period as is appropriate. This might involve remaining in the release community for a number of days.
- to visit the woman in the release community with some regularity while monitoring and continuing to educate key staff in the community support system.
- to identify, educate, and support key community workers in centers where the women typically move upon release. Since many of the women who are potential candidates for this program come from Newfoundland, support work in St. John's will be particularly important.

The community integration worker is essential to maximizing the likelihood of success in the woman adjusting to the support system upon release so as to reduce the potential for recidivism. This individual requires strong interpersonal skills to develop trusting relationships with the women, a hopeful, persistent and direct approach in order to advocate for resources, and sophistication in coordinating and educating community support workers.

Financial Resources for Community Integration. Each community release process and PSR plan will be unique to the needs of the individual and local resources, individual personalities and organizations, and particular arrangements. Standard community correctional centres with a majority of male residents and a large group-living situation are most frequently inappropriate for the release of these women. To facilitate community integration and effective individual release plans, funds must be budgeted within the PSR program to allow for:

- frequent travel to communities across the region, particularly Newfoundland.
- travel on an occasional basis by key community support workers in order to facilitate an understanding of the woman's experience within the penitentiary setting.
- training for key community workers in the PSR approach.
- additional contract support workers to support the women through a longer transition process in the community if necessary.

Cooperative Efforts for Partnership with Provincial Mental Health and Community Services. In both Nova Scotia and Ontario, provincial health and community service departments are recognizing the importance of psychosocial rehabilitation work at a conceptual and philosophical level, and some programs are in place, yet financial restraint has severely limited their willingness to serve women offenders since existing services are overburdened with their own clients. One potential strategy would be to work in partnership with key provincial decision-makers so as to contribute toward new joint programs that might serve clients from both jurisdictions from the outset.

Finding: The present correctional release process is ineffective for women with basic skill needs and cognitive challenges due to its failure to provide a bridge of consistent relationships for the women to the community setting. There must be a process through which to advocate for and develop individualized plans, including education of community support systems.

Recommendation 10: There must be an alternative release model in which a community integration worker builds a strong relationship with the individual woman in the penitentiary and then uses this relationship as a bridge to establishing her in a supported community setting. Sufficient funds must be provided to support this community integration process. The community integration worker must be based in the institution in order to develop the strong relationship with the individual offender that is required for success.

Staffing Complement, Qualifications, and Roles

Staff Complement. The following staff complement is proposed for the PSR program for a maximum of 8 women offenders. This complement is above any existing staff already present in the penitentiary. The complement should be:

- 1 full-time program coordinator

- 2 PSR workers on the day and evening shifts, seven days per week (one PSR worker must be a R.N. with psychiatric experience)

- 1 night security staff on the night shift seven days a week (ability to call in a second staff if needed)

- 3 days per week of an occupational therapist

- 2 days per week of a psychologist

- 1 full-time community integration worker

- 2-3 hours per week of a medical physician

- consulting psychiatry, chaplaincy, First Nations Elders, and community resource persons

- 1 day per week of contracted staff for specialty programs (e.g., art, music, skills-training)

- 1 day per week for an evaluation consultant (preferably this would be an additional day per week for the psychologist or occupational therapist, if either one has the required skills)

This complement is high relative to the existing complement of the regional facilities. However, it must be recognized that the purpose of this program is to transfer and maintain high-needs offenders presently in maximum-security facilities to the regional facilities. This staffing complement is low relative to the resources presently provided within maximum-security facilities. A significant part of the reason that these women have not been in, or have had serious difficulties in regional facilities, is because there have been inadequate staff resources to support them.

Program Coordinator Role and Qualifications. The coordinator should have the minimum qualifications of...

- a university degree in a social sciences, human services, or health field,

- experience in the correctional system,

- demonstrated skills and interest in working with women with serious difficulties/disabilities,

- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,

- an interest in and willingness to commit to a psychosocial rehabilitation approach,

- strong organizational and interpersonal skills to manage and facilitate the multi-disciplinary team.

The coordinator might be a person already working at a primary worker or higher level within the penitentiary who has demonstrated these qualifications through previous work. Although it would be preferred that the individual have mental health expertise and/or experience, the priority must be on hiring a person with strong interpersonal skills, interest in this group and approach, relevant core values, and organizational skills. The psychosocial rehabilitation skills can be learned through the staff training process defined below.

The coordinator should devote approximately half their time to leadership, coordination and administration and half their time to direct work and programming with the women offenders. The coordinator should be involved at a practical level in the program on a regular basis. The coordinator should be responsible for the overall direction of the program and should work cooperatively with staff members and the woman offenders to define the program.

PSR Worker Role and Qualifications. The PSR workers should have minimum qualifications of...

- a university degree in a social sciences, human services, or health field, and/or equivalent,
- demonstrated skills and interest in working with women with serious difficulties/disabilities,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- strong interpersonal skills,
- an interest in and willingness to commit to a psychosocial rehabilitation approach.

Preference should be given to workers presently at the facility if other qualifications were equal as a number of primary workers have expressed an interest in taking on job responsibilities which are more program oriented. Individuals would be required to voluntarily apply for these positions and they would be interviewed and selected through a formal hiring process. Additional casual PSR workers will need to be hired to fill in occasional spots in the rotation and to be available to move into the program quickly if full-time PSR workers leave with little notice or take leaves of absence. These casual PSR workers should receive the full PSR training but may be assigned other duties in the facility if possible when they are not required in the program. Overall, the staffing should be allocated so as to minimize regular part-time workers as they increase the size of the staff team and make team consistency and communication more difficult.

The PSR workers should work exclusively in the program on a three-year term basis on day and evening shifts. At the end of that term it would be the decision of the coordinator in consultation with the PSR worker as to whether the person would continue for another term or shift to another role in the facility. This would provide the opportunity for rotation and relief for individuals as work with these woman offenders can be extremely draining over time. It also would give the opportunity to provide cross-pollination of ideas and concepts between the PSR program and staff working with the general population.

The PSR worker role should involve direct, informal support work with the women in the setting, primary responsibility for psychosocial rehabilitation work with one or two individual women, monitoring of the setting, and assistance in specialized programming in the setting with other staff. The PSR workers should report to the program coordinator and must participate in the full psychosocial rehabilitation training program.

Night Security Staff. The women in the PSR duplex require supervision at night for security, support and supervision purposes. The night shift should be staffed separately such that there is no rotation between night, and day or evening shifts. The essential elements of the PSR worker roles on the day and evening shifts are to build strong relationships with the women and help with programs. he night shift does not provide an opportunity to carry out these roles and has a security and supervision function. If day and evening workers are placed on the night shift, it will require more program PSR workers to staff the duplex which in turn results in more staff with whom the women in the house must develop intensive relationships, and these staff would be present during the waking hours less frequently. This does not meet the needs of the women offenders who have difficulty developing relationships with larger numbers of staff and who require a consistent approach from a small staff team. Staff communication and informal consultation become more difficult, particularly with respect to facilitating a weekly meeting with most of the staff present on the day shift. Instead, the duplex should be staffed at night by a different set of workers whose function is to provide supervision if a woman is upset or wakes up. These staff must be regular Correctional Service of Canada employees who are able to intervene with the women when required.

The duplex would require at least one night security staff. A second person would be required if the women were particularly upset, or if the staffing of the institution on the night shift was such that one could not be count on a second person arriving in the duplex quickly in the case of an emergency.

Psychologist Role and Qualifications. The psychologist should possess the following qualifications:

- registration or candidate registration as a psychologist,
- demonstrated skills and interest in working with women with basic-skill needs and cognitive challenges,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- an interest in and willingness to commit to a psychosocial rehabilitation approach,

- demonstrated, effective interpersonal skills.

The psychologist should contribute formal assessment expertise to the team and should facilitate the multi-disciplinary admissions committee. The psychologist would also be a key consultant to staff and the multi-disciplinary team with respect to the design of individualized treatment and behaviour management programs. The psychologist would be expected to develop strong relationships with the individual woman and play a role in practical programs.

Nurse & Physician Roles. It is essential to have a registered nurse with additional psychiatric training and/or experience as a member of the staff team and this could be assured by requiring this qualification of one PSR worker, who would likely work a greater percentage of weekday shifts. The nurse must take responsibility for coordinating health care and work with the physicians for the women in the program. Physical complaints and drug-seeking behaviour are very common among women with these needs. It is complex and important to separate out legitimate uses of medication from drug seeking and it is difficult for doctors during brief consultations to gain the full picture without the presence of a well-informed nurse. The nurse should be present with the individual woman whenever possible during consultations with the doctor so as to understand what the woman is telling the doctor and to understand what the doctor has told the woman. The nurse is responsible for ensuring there is a consistent team approach to medical treatment. The nurse will also play an important role in the program with respect to health and medication education, providing individualized and small group programming with the women, and serving as a consultant to staff in working with these issues.

The physician must be an integral member of the multi-disciplinary team and time should be allotted for the person to attend at least a part of the multi-disciplinary team meetings so as to be aware of key health issues on a weekly basis. The physician should have a primary role, in consultation with the nurse, in determining medical policies and procedures. Referrals to specialists should be processed through the physician in order that there be a holistic approach to treatment.

Occupational Therapist Role. The occupational therapist should possess the following qualifications:

- registration as an occupational therapist,
- demonstrated skills and interest in working with women with basic-skill needs and cognitive challenges,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- an interest in and willingness to commit to a psychosocial rehabilitation approach,
- demonstrated, effective interpersonal skills.

The occupational therapist will play an essential role in individualized and small group skills-teaching in relation to the PSR plans. The occupational therapist will provide consultation and support to PSR workers and other team members in skills-teaching work with individual women as well as playing an important assessment role in evaluating the suitability of women for the program.

Excellent interpersonal skills, values, and experience are particularly important given the occupational therapist's leadership role in the skills-teaching areas. Occupational therapist training programs typically provide graduates with many of the key skills that are essential to quality skills-teaching in a psychosocial rehabilitation program. However, the sequencing and philosophy through which these skills are used in psychosocial rehabilitation departs significantly from many standard occupational therapy approaches. It is therefore particularly important that the occupational therapist be open to the PSR approach and participate fully in the training process.

Community Integration Worker. The community integration worker should possess the following qualifications:

- a university degree in a social sciences, human services, or health field,
- demonstrated skills and interest in working with women with serious difficulties/disabilities,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- strong interpersonal and advocacy skills,
- creative initiative in problem-solving,
- training and/or experience in developing and coordinating community resources,
- an interest in and willingness to commit to a psychosocial rehabilitation approach.

The community integration worker role has been described previously.

Spirituality. Psychosocial rehabilitation views recovery as a holistic process with a foundation of positive values. Many of the women who are potential candidates already have a commitment to spirituality in their life and this is an important pillar of support which should be strengthened in relation to their interests. The chaplain should play a valuable role through developing individual relationships with the women and supporting their spirituality.

Support for Cultural Diversity. Given the small group context, an individual woman from a First Nations, African-Canadian, or other distinct minority culture is likely to be isolated from her own cultural context in her living situation. It is essential to involve resource persons who can share and support her culture as an integral part of the PSR planning process. Provision must be made for key support persons to participate in elements of the psychosocial rehabilitation training in order that they appreciate the approach, and recognize its strengths and limitations in relation to the woman's cultural background.

Volunteer Support. Awareness of community opportunities is an essential element of the PSR approach in helping women to define goals and plan for the future. This process is difficult in a penitentiary context given security policies and procedures which restrict a woman's access to the community. Volunteers from the community can play an important role in working with women in one-to one programming. Simultaneously they can help to expand the woman's horizons by sharing who they are and their community perspectives.

Finding: High quality and committed staff are essential to an effective program. They must be committed to both direct work with difficult women and to the PSR program model. Although staffing is expensive for a program for these women with special mental health needs, insufficient or poorly trained staff will result in failure. The recommended staffing level is lower than the level of a maximum-security facility where these women would otherwise be maintained.

Recommendation 11: It is essential to select staff with strong interpersonal skills and values for work with these women while allowing for a mix of expertise to provide for diverse perspectives. Programming will be most effective if there is a small, multi-disciplinary staff who can support each other and provide a consistent approach to work with the women. Core staffing should include a program coordinator and a community integration worker, two PSR workers on day and evening shifts, a night security staff, and a part-time psychologist, occupational therapist, and program evaluation consultant. Part-time PSR worker positions should be avoided wherever possible, as intermittent staff presence makes communication and coordination more difficult. Night staff should only work on night shifts with a security and supervision function.

Staffing Training, Support, and Communication

Staff Training. Psychosocial rehabilitation is a precise, logical approach that requires practitioners who have a fundamental grounding in the values, a full understanding of each element of the approach, and the skills to apply it. Staff must bring a strong values foundation and set of interpersonal skills to the work and then must receive detailed training to be able to apply the approach with women who have great difficulties and can be extremely demanding of staff.

An eight-week training and team-building process should be provided over a six-month period beginning with a two-week team-building and psychosocial rehabilitation training component. This training must include the coordinator, PSR workers, occupational therapist, psychologist, and community integration worker. The eight-week program should include:

- six weeks of training in psychosocial rehabilitation technology
- one week of training in clubhouse and assertive community living approaches
- one week devoted to team-building, program planning and evaluation, and selected mental health topics

The psychosocial rehabilitation training course is provided in Canada through the Brockville Psychiatric Hospital and is based on the work of Anthony (1990). There are trainers in Nova Scotia and Ontario. It provides a detailed structured curriculum in which there are a series of training sessions which include presentation, modeling, and practice, followed by "homework" in which participants work through each module and set of skills with an individual woman. Sessions with the individual women are videotaped for feedback and supervision purposes. Time is required between modules in order that participants can work through the planning process with an individual woman.

A clubhouse training program is provided in Nova Scotia through the Connections Clubhouse in Halifax which has utilized this approach for more than a decade and has been cited as a model mental health program in Canada. The Connections coordinator is facilitating a workshop presented by Dr. L.I. Stein, one of the founders of the "assertive community living" approach in Halifax in June of 1998. Other key elements of the training with respect to team building, mental health topics, and program planning should be facilitated by the program coordinator in consultation with those with expertise within the correctional system and the relevant professional communities.

The eight week training process should be conducted in two groups on successive weeks so that there will continue to be some regular program staff working with the women during the training weeks. A brief two-day training program should be provided for the night security staff, physician, contract programmers, and relevant Elders and community resource persons. This program should be organized and facilitated by the program coordinator.

Staff hired from outside of the correctional system would be expected to participate in the standard training programs for work with women in corrections which are required of all staff.

Support and Communication. The program coordinator, staff team, and the institutional administration must recognize the importance of on-going team support and communication to make this program effective, as these women are extremely demanding on staff. Staff can quickly lose perspective and patience if they do not have communication and support within the team and from the broader facility. This commitment to team and communication must come from the individual staff but it requires an administrative context in which the legitimate use of staff time for team meetings, informal consultation, and support is recognized and supported. In particular, there must be opportunities on a regular basis for all of the key staff to meet together at one time. This requires funds to bring in or replace PSR workers.

Finding: Effective staff-training and support is essential to the success of the program and the ability to attract and retain quality staff.

Recommendation 12: All core staff must participate in an eight week training program including six weeks of training in psychosocial rehabilitation, one week of training in clubhouse and assertive community living approaches, and one week devoted to team building, program planning and evaluation, and selected mental health topics. A brief training program should be provided for auxiliary staff. There must be on-going commitment and resources for staff communication and support.

Program Evaluation

Given that this program represents a major new initiative involving high-needs women, program evaluation must be built into the process from the outset and should include a blending of qualitative and quantitative approaches with process and outcome measures. There are two options for obtaining program evaluation expertise. Preferably, the psychologist or the occupational therapist would have significant program evaluation expertise (possibly with some continuing education) and could design and carry out the evaluation in consultation with the team and the women. In the developmental phases of a program there are particular benefits to internal evaluation processes in that they encourage the staff team to build a continuous quality improvement ethic into all of their work on a daily basis. However, if there is no one with this particular expertise on the team, then an external contract should be tendered for a professional to design and complete the evaluation work in consultation with the staff team and the women offenders. It is expected that the evaluation would require one day per week for the first two-year period. If the psychologist or occupational therapist took on the evaluation role, they would require an additional day per week to fulfill the task.

Finding: Program evaluation is essential to program improvement and accountability.

Recommendation 13: Either a team member with evaluation expertise or an external consultant should design and conduct the program evaluation in consultation with the staff team and the woman offenders.

Implementation of a Pilot Program

Based on the analysis of the women presently in maximum-security facilities who would be potential candidates for this program (see Section II), it is recommended that this program model be applied and evaluated initially through developing one duplex with eight spaces at Nova Institution in Truro, Nova Scotia. There are presently four women at Springhill who are candidates for this program and there are two additional candidates from Atlantic Canada in the Special Needs unit of the Prison for Women. This disproportionate number from Atlantic

Canada makes Nova the reasonable location. In addition the program should be open to women from other regions with basic skill needs and cognitive challenges. It might be appropriate to begin with six women, three per side, in order to allow the staff team and facility to gain experience with smaller numbers. Once the program is operating, it may be possible to involve appropriate individual women who are functioning effectively in regular houses in a psychosocial rehabilitation planning process and relevant programming yet they would remain in a regular house.

The proposal to begin with one program at Nova Institution which may accommodate some women from other regions does conflict with the concept of trying to serve women as close to their home communities as is possible. However, this program requires a high level of resources, and given the very small number of women with basic skill needs and cognitive challenges, it makes sense to start small and recognize that it may not be possible to provide every special and intensive mental health program in every region. The program is voluntary but it does put the woman in the situation of moving from her region if she wants to participate in a program that may be most suited to her needs. However, for many of these women, they do not have significant supports in their home communities given their long term difficulties and time spent in institutions. In addition, the regional facilities serve extremely large regions at present, such that women are often at a great distance from their home communities. The increased distance if she is in another region may not be psychologically significant. If the program model proves effective and there are the sufficient numbers, a second program can be implemented in another region so as to maintain more women in their own region. It also might be possible to provide a modified program model in a maximum-security facility if there were enough women with these types of needs who could not obtain a medium-security classification due to persistent and severe behavioural difficulties.

Obstacles to Effective Implementation of the Program

The following issues could become major obstacles to the implementation of an effective program and therefore must be recognized and strategically addressed from the outset:

1. Failure to hire and/or maintain quality staff. Strategies to avoid this problem include:

- the provision of adequate time and attention to hiring.

- ensuring there are individuals on the hiring committee who have direct experience working with these women and this type of program.

- drawing on existing staff who have demonstrated exemplary performance for the PSR worker positions.

- an upbeat recruiting effort which emphasizes the innovative nature of the program to attract specialty disciplines to a small-town Nova Scotia community.

· an administrative and resource priority on providing time for staff training, support and communication.

2. Conflicts with broader penitentiary policies and requirements. Potential strategies to avoid these problems are:

· a clear vision and written program description recognized throughout the institution which allows for a relatively high level of program autonomy.

· a formal, documented multi-disciplinary admission process with clear criteria that is honoured at the institutional, regional, and national levels, even if there are operational pressures to take contrary actions.

· initial start-up planning time involving the administration and staff team in order to identify and problem-solve with respect to potential policy conflicts.

· a flexible administrative approach to the program and a willingness to grant reasonable autonomy and support staff judgment.

· a staff team with correctional experience that recognizes policy concerns in a penitentiary.

· on-going efforts by the staff team to educate other staff and women offenders about the purpose, practices, and challenges of the program. Recognition by the staff team of the potential for resentment from other staff with respect to new resources for a new program when existing resources are limited.

· program participation in regular communication forums at all levels in the institution.

3. Inability of the staff team and the local administration to control planning decisions. Potential strategies to avoid this problem are:

· ensuring that staff are hired and in place in advance of program-start-up. This includes hiring key staff as soon as possible, even if they perform some other functions initially while the planning and implementation process gathers momentum. Pressure must be resisted to proceed too quickly given the priority on transferring individual women out of maximum-security environments.

· ensuring that there are effective mechanisms for staff control and input into the building design at a detailed level so that the structure reflects programming and security needs. Problems in the physical structure can be a permanent drain on the program and staff.

· ensuring that the program has flexibility with respect to policies and procedures wherever appropriate.

4. A rapid and ineffective transition process for individual women transferring from maximum-security facilities. Potential strategies to avoid this problem are:

- education of the staff at the existing maximum facilities with respect to the program so that they can realistically present it to potential candidates, set appropriate expectations, and facilitate the transition process.
- education work with the individual women by the program coordinator before they come to Nova.
- accompaniment of the women on the transfer by those they trust from the maximum-security facilities.
- careful planning for and a staggered transfer of women so that they do not all arrive simultaneously.

Recommendation 14: Specific strategies must be adopted from the outset to overcome these obstacles to the effective implementation of the PSR program with women offenders..

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V. Dialectical Behaviour Therapy and Programming For Women with Emotional Distress Needs

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Program Evaluation
Obstacles to Effective Implementation of the Program

Dialectical Behaviour Therapy represents one of the most prominent approaches to work with women with borderline personality disorder in North America and has clinical research utilizing controlled trials to support its effectiveness (see Linehan, 1993). It has been applied in forensic settings and appears to offer the most promise of available approaches for work with women whose emotional difficulties and behaviours are very problematic and resistant to change, particularly those with patterns of persistent self-destructive and/or suicidal behaviour. It is proposed that this model be utilized as the basis for a structured treatment program and living environment at Grand Valley Institution in Kitchener Ontario which should (1) serve women already present at Grand Valley who are not able to cope with life in regular houses due to their emotional distress and severe behavioural difficulties (e.g., the enhanced unit at Grand Valley is at present full), and (2) allow some women in maximum-security facilities (i.e., P4W) to be supported and maintained at regional facilities. It is proposed for Grand Valley because a preponderance of women with these difficulties are in Ontario and the priority is to support and manage women with high needs but low risk in the least restrictive environment that is appropriate. This approach could be applied at any regional or maximum-security facility if it proves valuable and the numbers warrant it.

A majority of the women with high emotional distress exhibit a combination of difficulties characterized by self-destructive, para-suicidal, and/or suicidal behaviour, emotional dysregulation, severe interpersonal relationship problems, unstable and low self-image, and cognitive disturbances and distortions. The DBT model is suited to these persons and the distribution of them across facilities is categorized in Table 2. However, there remains a small group of women with emotional distress needs (four persons at present) who are suffering from the acute symptoms of major mental illness. They deserve consideration before proceeding to outline the proposed DBT model for women with behavioural difficulties.

Those suffering from the acute phases of major mental illnesses would not be appropriate for a dialectical behaviour therapy program unless they suited the behavioural criteria once the acute symptoms of their illnesses were under control. Existing resources, assuming the PSR and DBT programs are in place, should serve the needs of this small group of women. At the regional facilities, either use of the enhanced unit with psychological and psychiatric supervision, or referral to a psychiatric hospital, if the difficulties are extreme, would be appropriate. P4W has similar options and a higher level of mental health expertise to cope with women with this constellation of needs at a maximum-security level. Once their acute symptoms are under control, it is important to assess (1) whether they are appropriate for a regular house at a regional facility, (2) whether they are appropriate for either the PSR of DBT programs given their additional difficulties, or (3) whether they require the treatment and structure of a maximum- security facility.

There is no indication that this very small number of women suffering from acute major mental illness will out grow existing resources in the foreseeable future. There is a negative correlation between serious criminal behaviour and major mental illness. Although on-going de-institutionalization of psychiatric hospitals could leave more of these women in the community in jeopardy, these illnesses are typically seen as appropriate and potentially responsive to mental health treatment by mental health professionals. These women are likely to be served in a crisis and less likely to end up in the correctional system. In addition, some of these women who have committed criminal acts are likely to be found not guilty by reason of insanity and placed on a forensic or general psychiatric unit.

Table 2: Women with Emotional Distress Needs-
Acute Major Mental Illness versus Severe Behavioural Difficulties

	Nova	**Springhill**	**Prison for Women**	**Grand Valley**	**Totals**
Acute Major Mental Health Needs at Medium-security				2	2
Acute Major Mental Health Needs at Maximum-security			2		2

Emotional Distress Needs: Potential for Medium-security		1	3	[illegible]*	8
Emotional Distress Needs at Maximum-security		1	1		2
Totals		2	6	6	14

* It is very difficult to assess numbers in this category as Grand Valley staff presented 4 additional women with significant emotional distress who for the moment are doing better with special supports in the regular houses. These women might need more support over time through a special living environment, while those who are now unable to cope within the regular houses might improve. Given the rapid changes in emotional stability among women with this constellation of needs, it is difficult to predict an individual's need for a specific placement a number of months into the future.

The one area in which resources for serving women with major mental illnesses are clearly deficient is in the absence of nurses at the regional facilities who have additional psychiatric training and experience. This is inappropriate for serving women with major mental illnesses, even it there are only a few, and is also extremely problematic in the overall work of nurses with the entire population of offenders, regardless of whether they have special needs. There is a constant overlap between health, mental health, and substance abuse issues when women offenders seek health care at regional facilities such that nurses require training in all three areas. For example, nurses are the front-line staff who have to assess and react to self-injury, and consider the subtleties between legitimate physical complaints and drug or attention-seeking requests. The failure to adopt a holistic approach by integrating mental health and health expertise in the nursing positions contravenes key principles in both *Creating Choices* and the *Mental Health Strategy*.

Finding: Existing mental health resources, assuming that new resources are put in place for the DBT and PSR programs, are sufficient to serve the small number of women suffering from major mental illnesses with the exception of a serious deficiency in psychiatric nursing at the regional facilities.
Recommendation 15: New nurses hired within the regional facilities should be required to have psychiatric training and/or experience. Existing nurses should be offered an extensive inservice training program to upgrade relevant mental health and substance abuse expertise for working with women offenders. Existing psychiatric nurses at the Prison for Women would be helpful in defining the training program.

Conceptual Basis for Dialectical Behaviour Therapy

Linehan (1993) conceptualizes five areas of "dysregulation" in which women with borderline personality characteristics exhibit severe behavioural difficulties:

- emotional dysregulation: emotional instability, problems with anger, etc.
- interpersonal dysregulation: intense unstable relationships, efforts to avoid loss, etc.
- behavioural dysregulation: para-suicide, self-damaging behaviour, impulsivity, etc.
- cognitive dysregulation: rigid, dichotomous thinking, cognitive disturbances, etc.
- self dysfunction: chronic emptiness, low and unstable self-image, etc.

She places particular emphasis on addressing self-injurious behaviour and self-damaging acts, behavioural difficulties that are particularly prominent for women offenders with high emotional distress needs. Linehan (1993) views their difficulties from a biosocial perspective which includes emotional vulnerability and dysregulation as biological predispositions combined with an "invalidating environment" where a woman is taught not to properly label or trust her own emotional experiences. Histories of physical and sexual abuse are particularly characteristic of women with these difficulties, and abuse is in many ways the most extreme form of invalidation.

She notes the highly reactive and unstable nature of behaviour exhibited by these women which swings between...

- *emotional vulnerability* (extreme sensitivity and inability to cope with emotions) and *self-invalidation* (tendency to deny emotions, accept others' interpretations of events, simplify problems).
- *active passivity* (a helpless approach to problem-solving in which assistance is sought from others) and *apparent competence* (seeming ability to cope effectively on one's own).
- *unrelenting crises* and *inhibited grieving* (inability to experience emotions, a numbness to events).

Roots of DBT Approach

The DBT approach for working with these women is rooted in three philosophical and therapeutic traditions:

(1). *Cognitive-Behavioural Approaches:* DBT builds on a cognitive-behavioural foundation of work over the past two decades which has proven helpful in treating a wide range of psychological difficulties and mental health problems. These systematic, detailed and step-wise approaches to learning and change have given practitioners a solid framework through which to address difficult problems with clients, particularly in instances where they are motivated to work on the issues.

(2). *Humanist Relationship Approaches:* Linehan (1993) strongly argues that cognitive-behaviour treatment approaches alone, since they represent a technology of change, are insufficient for these women who have a great fear of change and a need for validation and acceptance. Thus Linehan's work also places emphasis on building trusting relationships with clients and accepting them as individuals. It is essential to find ways to validate their behaviour, while still working toward change. Practitioners must avoid the trap of blaming the victim for her problems which have their roots in her biosocial difficulties.

(3). *Dialectical Theory:* The final important element is based on the conceptualization of individuals' difficulties as extreme responses to problems, including the tendency to swing from one extreme to another. Drawing on eastern dialectical philosophy, Linehan emphasizes the need to validate divergent and potentially conflicting strategies in approaching a problem, representing a thesis and an antithesis, with the goal being to bring them together in a synthesis which recognizes the truth in both extremes. The individual must learn to balance antithetical approaches and find a middle path. Mindfulness practices represent an important tool in this work.

Applicability of DBT to Women Offenders With Emotional Distress Needs and Severe Behavioural Difficulties

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A significant number of women with emotional distress needs characterized by severe behavioural difficulties have been unable to function in the group living environment of the regional facilities, or in the community. Their high levels of emotional distress result in "unrelenting crises" which upset others in the environment and create intense and unstable relationships. The tendency to self-injurious behaviour results in a need for supervision, upset in the living environment, and the need for a coherent staff response so as to reduce the likelihood of this behaviour increasing over time. The increased stress results in a cyclic increase in the distress of these women, as well as others, and more problematic and self-injurious behaviour to the point that the living environment becomes very unstable and explosive. In the community, these women have frequently exhibited similar patterns of difficulty and intermittent involvement with the mental health system. However, mental health professionals often become frustrated and feel hopeless in their efforts to help them address their problems, and as the result they may eventually be denied treatment or refused admission to psychiatric inpatient units. Criminal behaviour can provide another means to gain access to professionals who will care for them. In many instances these women may exhibit anti-social traits which result in behaviour that brings them in conflict with the law.

The following strengths are frequently present among these women and must be acknowledged in the program model:

· *Ability to Function Well at Specific Times in Specific Environments:*

Women with these needs can be very competent under specific regimes and circumstances and yet unable to function in other situations despite their "apparent competence." A valuable therapeutic response is to maximize and support their competence so that it can generalize to other circumstances and settings.

· *Trusting Relationships Provide Structure and Support:* Linehan (1993) emphasizes this as a key strength that should be built on through providing these women with trusted individual relationships as a part of the treatment process. They do the best when they have valued significant others and/or trusted therapists who can effectively handle their crises and demands while supporting them to learn more effective coping strategies.

· *Moods and Mental State are Reactive to Internal and Environmental Cues:* Individuals are very changeable and strongly influenced by their immediate environment. Support, consistency, and a sense of security facilitate positive behaviour while stress in the environment or difficulty with their relationships results in self-destructive behaviour and the inability to cope.

· *Strong Need for Others and Easily Influenced by Peers:* These qualities represent strengths assuming they are living in environments where they have pro-social peers. For example, one woman at Nova has made very significant gains in the last year in large part because she was able to separate herself from a partner who appeared to have an extremely negative influence on her behaviour.

· *Responsive to Structure if it is not Perceived as Hostile:* Structure provides a sense of security which is helpful to them as they learn better coping skills, and also allows for the development of trusting interpersonal relationships. However, if they or their peers view this structure as hostile (e.g., us versus them), they may also act out strongly against the program and staff.

· *Normal and Above Normal Cognitive Abilities:* Emotional rather than cognitive difficulties typically define this group of needs. Their cognitive abilities can be a resource for growth and change.

· *Criminogenic Attitudes are Less Dominant and Open to Modification:* These individuals have ended up in the correctional system primarily due to their inability to cope in the community, their deficits in coping and problem-solving skills, their lack of supports and resources, and their emotional disabilities, rather than due to anti-social attitudes and lifestyles. Where they have developed these attitudes, their desire for trusting relationships and susceptibility to influence by peers can be used to help them move to a more pro-social perspective.

· *Music, Art and Creative Expression are Valued Methods of Communication:* Many of these individuals have a particular affinity and strength for communication through the creative arts, possibly because of the depth and richness of their emotional experiences.

The following limitations and/or skill and resource deficits frequently apply to women with this constellation of needs and must be recognized within the program model:

· *Sense of Hopelessness and Powerlessness:* Their emotional vulnerability, unrelenting crises, coping difficulties, and past failures in helping relationships result in a sense that things will never improve, providing one important motivation for suicidal behaviour. This hopelessness must be overcome if the person is to grow and learn. It requires skilled staff and a living environment with hopeful, pro-social core values intrinsic to all activities that are modeled and lived by staff.

· *Emotionally Reactive, Have Difficulty Recognizing and Regulating Emotions:* Their skill deficits in recognizing, labeling, and regulating their emotions result in extreme and impulsive behaviours. Training in these skills is an important element of effective support and treatment.

· *Peer Relationships Produce Stress Given Poor Relationship and Problem-Solving Skills:* Connection to others is very important yet their weak relationship and problem-solving skills result in interpersonal conflict and a stressful environment in which they are unable to cope. Even medium sized groups (6-8 persons) increase the interpersonal confusion and potential for conflict.

· *Reactivity to High Stress Environments:* Individuals tend to react quickly and impulsively to stressful situations and settings with difficult behaviours, particularly self-harm. They require a program structure and level of supervision which can reduce stress levels and provide staff support. However, this setting needs to support their independence and ability to effectively apply new coping skills.

· *Inadequate Strategies to Cope with Stress:* One major source of the behavioural difficulties for these women is their lack of effective coping skills. Self-harm is often one ineffective and dangerous means to cope with stress. Effective skills-teaching in this area is imperative.

· *Past Failure and Low Self-Confidence Are Obstacles to Learning and Growth:* New tasks and environments are associated with failure and thus learning programs and change must be based on slow, small incremental steps and personal successes.

· *Difficulty in Maintaining Long-Term Trusting Relationships:* Although women with these needs particularly value trusting relationships, they often are so demanding of these relationships that others eventually reject them. This is a particular issue for practitioners working with these women if they do not have a high degree of support from peers and supervisors.

· *Difficulty in Transferring to New Environments without Consistent Relationships:* It takes time and individuals may have great difficulty developing the trusting relationships which are essential to helping them to learn the coping skills required for independent functioning and success. They have difficulty making the transition to new environments because they lose their previous relationships and are confronted with their fears given past failures. They are often unable to ask for help from those they do not know or trust. It is important that the trusting relationships support them through the transition to a new environment, be it the regional facility or a community setting, if they are to make a successful adjustment. Strong practitioner values and interpersonal skills are essential to developing trusting relationships.

Dialectical behaviour therapy is directly applicable to working with women with this constellation of needs and behaviour difficulties, particularly given their pattern of self-harm and self-damaging behaviour. However, there may be some differences between these women and those that DBT originally focused on in that these women have had significant conflict with the law as the result of their behavioural difficulties. Linehan's work originated in a mental health context. Yet the hierarchy of behavioural targets for intervention via Linehan's approach is easily modified to give more priority to acting out anti-social behaviours if necessary.

A common dialectical behaviour therapy model to be shared across a multi-disciplinary staff team is also imperative given that these women offenders are extremely demanding and staff require on-going support from each other, a strong team, and administration, to maintain the hopeful core values and the detailed skill development that is required for success. These women frequently divide staff in terms of appropriate treatment responses, ranging from staff who may advocate unconditional support to others advocating a hard-nosed posture of challenge. One of the particular strengths of the dialectical approach is that it recognizes the elements of truth in conflicting staff responses, just as it does in the extremes of the women's behaviour. This allows a framework through which staff can synthesize and interpret their differences. Staff and administration require a clear program structure and framework to fall back upon when they confront the complex interconnections in working with women with these needs and difficulties.

Dialectical Behaviour Therapy Program Purpose and Objectives

The ***purpose*** of the dialectical behaviour therapy (DBT) program is to support women offenders with emotional distress needs and severe behavioural difficulties to live successfully in regional penitentiary facilities while gaining skills which will enable them to move to and experience satisfaction and success in regular housing at the regional penitentiaries, and/or in the community, reducing the likelihood of recidivism.

Objectives. By participating in the dialectical behaviour therapy (DBT) program, women offenders with emotional distress needs and severe behavioural difficulties will...

- increase coping, problem-solving, and communication skills in areas of need.

- function in a regional facility without persistent acting out difficulties.

- establish and follow through on a community correctional plan for release that will reduce the likelihood of recidivism.

- demonstrate increased self-esteem.

Finding: The dialectical behaviour therapy approach is the most appropriate and potentially effective programming model for individuals with emotional distress needs and severe behavioural difficulties such that they can reside in the least restrictive environment in a regional facility. Ontario has a disproportionate number of women with this constellation of needs.

Recommendation 16: Implement the dialectical behaviour therapy approach for women offenders with emotional distress needs and severe behavioural difficulties at Grand Valley Institution in Kitchener, Ontario through a specific program model which is appropriate for regional facilities. This model shall reflect the specific strengths and limitations of the women with this constellation of needs and be based on a specific purpose and set of objectives. Given the limited clinical resources presently at Grand Valley and the high demands on those who are present, it is recommended that senior staff from Prison for Women who are familiar with DBT approaches serve as consultants to Grand Valley Institution in setting up the DBT program.

Admission Criteria and Assessment Process

The following criteria are required for admission to this program:

1. *Voluntary agreement by the individual woman to participate.* It must be recognized that women with these needs are extremely changeable in their willingness to participate in any setting or set of activities and therefore their agreement should be developed over time through a trusting relationship in which they are encouraged to take time to understand their choices. The withdrawal of consent should also require time and working through a discussion process with a trusted person.

2. *A medium- or minimum-security classification.*

3. *Recommendation for participation by the multi-disciplinary team* at the regional facility responsible for assessment for specialized mental health programs based on:

    a. Significant deficits and needs in problem-solving, interpersonal communication, and coping skills exhibited by severe behavioural difficulties with respect to emotions, interpersonal relationships, observable behaviours, cognitions and/or sense of self. The individual is likely to exhibit self-destructive behaviour.

    b. Emotional needs and dysregulation rather than criminogenic attitudes and lifestyle are the most prominent causes of incarceration and acting-out behaviour.

    c. Requirement for on-going support and supervision by staff in the living environment to solve problems, cope with peer relationships, and/or manage inappropriate behaviours.

    d. Ability to perform basic life skills and household tasks.

e. Cognitive abilities within the normal range. Not suffering from the acute phase of a major mental illness.

The multi-disciplinary team responsible for assessment for specialized mental health programs shall include the following positions and/or disciplines:

- psychologist
- registered nurse with psychiatric training and/or experience
- coordinator of the dialectical behaviour therapy program
- warden and/or deputy warden
- intake or case management officer
- team leader or director of programs
- community integration worker for the DBT program
- coordinator of the psychosocial rehabilitation program (if existing at the facility)

Linehan frequently identifies her approach as appropriate for persons with "borderline personality disorder." This diagnostic category is not strictly utilized in the admission criteria for this program for a number of reasons. First, Linehan (1993) legitimately criticizes standard diagnostic categories as being clinically and ideologically motivated, recommending a revised behavioural approach based on the clusters of difficulties with respect to emotions, interpersonal relationships, observable behaviours, cognitions and sense of self. Second, the "borderline personality" diagnosis has been problematic in recent years in that it has become somewhat of a fad diagnosis for women for whom the mental health system has been unable to provide effective treatment. Finally, the notion of "personality disorder" implies an on-going and permanent set of traits less amenable to treatment and change. This runs counter to an approach with hopeful core values which works toward positive behavioural change. It is preferable to leave the criteria for admission to a multi-disciplinary team with the expertise to assess women offenders and their behavioural difficulties on an individualized basis.

Inevitably, given the characteristics of women offenders, individuals will demonstrate a mixture of emotional distress needs and anti-social attitudes and behaviour, and it may be difficult to discern the more prominent set of needs. The prominent needs may also shift with time and the woman's experiences. It makes sense to begin with women who most clearly exhibit an emotional distress constellation of needs. DBT holds potential to address the needs of women with anti-social attitudes and behaviour if they are willing to establish a therapeutic relationship and commit to a treatment process, however these qualities are less likely with women with stronger anti-social attitudes. Women with anti-social attitudes who strongly resist a therapeutic process could easily sabotage the living environment for women who are appropriately placed. Over time, staff will gain DBT skills and experience and will be better able to judge the flexibility of the approach.

Finding: Matching the needs of individuals with the program goals and structure is essential to success. Inappropriate mixes of women offenders will compromise the effectiveness of the program and represent a major threat to its effectiveness. This is a particular problem given the potential for operational pressure to place inappropriate women in the program simply as a result of their needing higher levels of supervision.
Recommendation 17: A formal multi-disciplinary assessment process with admission criteria based on the consent of the woman offender, a medium or minimum security classification, significant coping, communication and problem-solving skill needs, and the need for staff supervision, is required for entry into the program. There must be an official, approved program description with clear admission criteria which requires staff at the regional facility to make the final decision on admission.

Dialectical Behaviour Therapy (DBT) Core Assumptions

Linehan (1993, pp. 106-107) identifies the following assumptions (core values) as essential to the DBT approach:

1. Clients are doing the best they can.

2. Clients want to improve.

3. Clients need to do better, try harder, and be more motivated to change.

4. Clients have not caused all of their own difficulties but they have to solve them anyway.

5. Clients' lives are unbearable as they are currently being lived.

6. Clients must learn new behaviours in all relevant contexts.

7. Clients can not fail in therapy.

8. Staff require support to work with these women.

Underlying themes that run through the treatment practices include the need for practitioners to maintain a hopeful approach and avoid blaming the women for their behaviour and difficulties. It is also important to obtain the offender's agreement and commitment to reduce their self-injurious behaviours and work toward a better future, even if they can not foresee success.

DBT Behavioural Targets for Change

DBT defines a hierarchy of behavioural targets for change across three stages of treatment such that the individual focuses moves from higher to lower priority targets as their control over their behaviours increases (Linehan, 1993; p. 167).

- Pretreatment: Orientation to treatment and agreement on goals
- Stage 1

1. Decreasing Suicidal Behaviour
2. Decreasing Therapy Interfering Behaviour
3. Decreasing Quality of Life Interfering Behaviours4. Increasing Behavioural Skills
    - Mindfulness Skills
    - Interpersonal Effectiveness
    - Emotion Regulation
    - Distress Tolerance
    - Self-Management

- Stage 2

5. Decreasing Post-Traumatic Stress

- Stage 3

6. Increasing Respect for Self
7. Achieving Individual Goals

For women offenders, serious behaviour problems and/or anti-social attitudes within the institution (e.g. substance abuse, assault, verbal abuse, etc.) would likely be incorporated into the target of "quality of life interfering behaviours" which are those which "jeopardize any chance... of a life of reasonable quality" (Linehan, 1993; p. 177). These behaviours jeopardize the opportunity for the person for lower security classifications and early release as well as the ability of the person to remain in the community without engaging in criminal activity.

This hierarchy of behavioural targets provides the priority list for what is addressed through the treatment program, although there are distinctions as to which targets receive priority in each component of treatment. A particular strength of this approach is the emphasis on agreed upon behavioural priorities as women with these needs typically have an unending series of crises that make it extremely easy for both staff and offenders to lose focus on treatment priorities.

Components of DBT Treatment

1. *Individual Counseling and Skills Coaching:* This component involves regular individual counseling sessions with a DBT approach and behavioural targets. The priority is to develop a constructive and trusting relationship with an initial focus on reducing self-injurious behaviour and on maintaining the person in treatment. Keeping a person in treatment includes the need to maintain the commitment of the client as well as the counselor. Joint agreements, clear expectations, and the acknowledgment of difficult behaviours exhibited by both the offender and the counselor in relation to each other are discussed. The counselor must validate and help deal with the woman's on-going difficulties while coaching her to apply core skills (see below) to her daily problems. It is proposed that these sessions occur one to two times per week on a regular basis with a trained psychologist. A behavioural background is essential to this work as well as advanced clinical training given that there are high levels of clinical complexity and an on-going risk for suicide in working with these women on a regular, individual basis. It is important to set boundaries on these relationships so that the psychologist does not become responsible for the woman's problems and lose the focus on supporting her to learn new skills and function independently.

2. *Structured Group Skills Training:* Linehan (1993a) provides a specific group skills curriculum to help women develop core skills necessary to improve their coping and problem-solving abilities so as to meet their behavioural goals, reduce self-destructive behaviour, and improve their levels of functioning. The core skill areas are: mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and self-management. Skill development in these areas is directly linked to the needs of these women offenders. The group training process should occur twice per week in a structured group format where the focus is on learning skills in an educational context rather than addressing individual problems in a therapeutic context. This group process including up to eight participants should be led by two DBT workers with specialized training as group-skills facilitators. It is important for different staff members to take on the individual counseling and group training roles in order to communicate the distinction in the goals of the two components. The group skills program consists of presentations, practice, and homework relevant to applying the newly learned skills to daily activities and difficulties. One session per week may be devoted to the review of homework while the second session presents new material. Women frequently benefit from repeating the six-month program a second time as a means to solidify their understanding of the skills.

3. *Brief Daily Meeting of Women in the Living Setting:* The focus of this session should be to facilitate cooperation among the women in the living environment, to openly identify any key conflicts and provide an opportunity to utilize core skills to address them, and to organize household tasks. It should also be a forum through which the women can develop a sense of ownership in and responsibility for their living

environment. Depending on the specific group of women, the agenda may need to be structured so as to avoid becoming consumed by individual crises and needs that are more appropriately addressed in individual counseling sessions. These sessions should be facilitated by the DBT workers.

4. *Informal Staff Support and Consultation:* Linehan (1993) argues that counseling and skills training sessions amount to the "practice field" for women with emotional distress while their daily activities are the "real" thing. Therefore, much as a sports coach would never dream of missing the actual game, so the individual counselor or skills trainer should be available (within reasonable, agreed upon limits) for informal coaching during the daily crises of these women's lives, whether the support person is actually present or consulting by phone. This consultation is critical to helping the woman actually apply the skills in real situations. It is up to the program team to determine who is responsible for particular issues with respect to this coaching process with a woman. It could in some instances be the psychologist conducting the individual counseling while in other instances it might be a DBT worker on a particular shift. It is important for coaching purposes that a DBT worker to be regularly accessible in the living environment.

The DBT program should also be available to women with high emotional distress needs whom may still be able to live in regular houses as long as they have regular support and structure through individual counseling and coaching, group skills training, and informal staff support and consultation. These women should participate in all elements of the program yet they should not take a place in the small group living setting. Overall, it is essential that there be a strong multi-disciplinary team overseeing the program, particularly the interrelationships between the various treatment components.

Finding: There are four interrelated components to conducting a DBT program and their must be overall effective coordination between them by the multi-disciplinary staff team.
Recommendation 18: The individual counseling and coaching, group skills training, daily meetings, and informal staff consultation components must be implemented in a coordinated manner by a multi-disciplinary staff team with specific training in the approach. The DBT program should also be accessible to a limited number of women with emotional distress needs who are able to cope in regular houses with the extra support provided by the program.

Characteristics of the Physical Living Environment

Women offenders with these needs require a small group living environment with a regular staff presence in order to minimize stress and allow for the time and space to implement the DBT process. It is proposed that it take the form of a one-story duplex, with each side serving up to four women. It should be built...

- to mirror the appearance of a house in a community context,

- to minimize dangerous objects in the environment in the event of acting-out behaviour,
- to provide regular staff supervision,
- to provide residents with a continuum of options and locales through which they can take greater or lessor responsibility, depending on the circumstances, for coping with stress and potentially explosive or self-destructive behaviour.

Careful planning involving architects, staff (including front-line staff and the DBT program coordinator), and women offenders, is required to simultaneously maintain a home-like appearance while minimizing dangerous objects and providing security for emergencies. Architects must take practical direction from experienced staff in defining the detailed elements of the house (e.g. types of lights, size of halls, ability to lock various areas, etc.). The program coordinator must be hired as soon as is possible and must be responsible for gathering and facilitating staff and offender input into the design. With respect to the offenders, gathering input will include the coordinator visiting women in maximum-security facilities who are potential candidates for the house, explaining future placement possibilities, and seeking their input into the design. A committee made up of the lead architect, the builder, the warden, and the DBT coordinator must have the final authority on all phases of the design and construction process.

Figure 3 presents a draft proposal for the duplex design. It is identical to the proposal for the PSR duplex with two exceptions. The bedrooms would not require the capacity to be locked down and the staff space would be a separate room. For the DBT duplex, there will not be a staff presence in the building at all times and there must be an ability to secure this area. The design should meet the following criteria:

- A maximum of four clients per side in order to maintain a small group size while providing for adjacent dwellings so that staff can be shared. The two separate sides provide for flexibility in separating incompatible women. Although four persons per side is a small number, it must be recognized that increasing the size of the group is akin to an exponential increase in problems due to all of the new relationships which are introduced, rather than simply adding one additional person.
- A home appearance which is attractive and bright and allows for women to decorate walls, have comfortable furnishings, and include plants. The interior design should facilitate women being able to make choices on the appearance of their home while decisions by one set of women can be altered by a later set (e.g., use of bulletin boards or picture frames in which images can be shifted).
- Multiple quiet and separate spaces for women should be available while maintaining reasonable ability for staff to monitor the setting.
- Facilities for therapeutic quiet (see below) should be available and buffered by staff space. They may be used for a woman at the discretion of the woman offender or as required by staff policies and procedures. An immediate bathroom facility should be available in the therapeutic

quiet area so that a woman does not have to return to the main living environment.

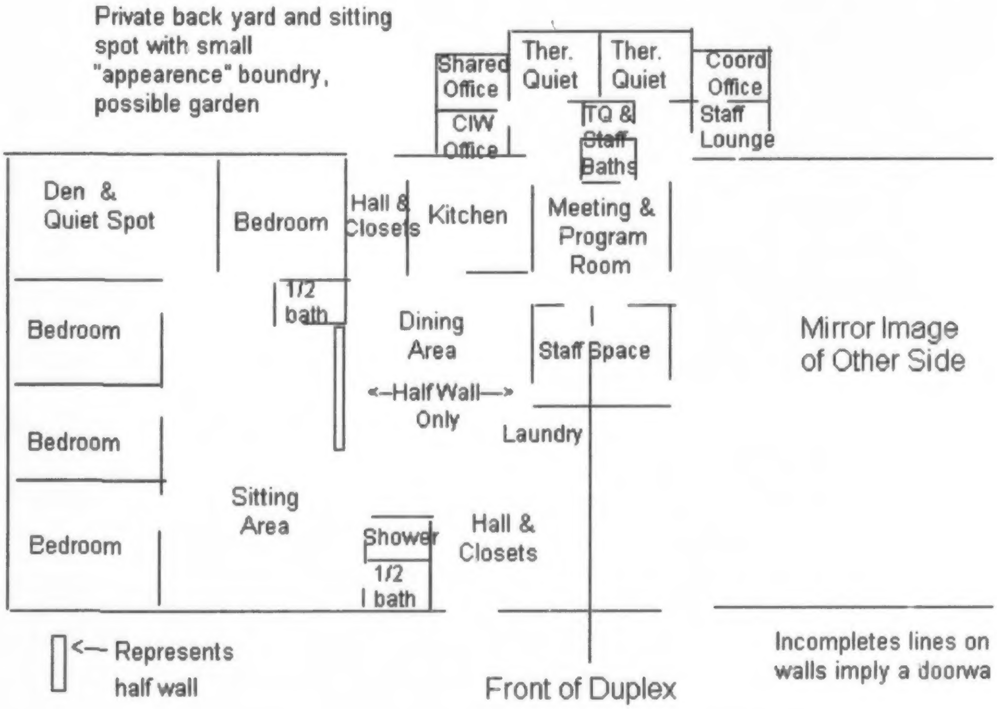
- Two small bathrooms for residents.

- High quality sound insulation is required between the two sides of the duplex, between the bedrooms, and insulating the Den/Quiet Spot, so as to reduce the possibility of one person upsetting another. The quiet spot must be an attractive, peaceful, and relaxing room with good natural light.

- A full kitchen should be available for preparing all meals and should open on to the rest of the house, yet be able to be locked when necessary (e.g., double doors might be used to close it off).

- A dining area with a table for meals should be adjacent to the kitchen.

Figure 3: Proposed Floor Plan for the DBT Duplex


Private back yard and sitting spot with small "appearence" boundry, possible garden
Shared Office
CIW Office
Ther. Quiet
Ther. Quiet
TQ & Staff Baths
Coord Office
Staff Lounge
Den & Quiet Spot
Bedroom
Hall & Closets
Kitchen
Meeting & Program Room
1/2 bath
Bedroom
Dining Area
Staff Space
Mirror Image of Other Side
<--Half Wall--> Only
Laundry
Bedroom
Sitting Area
Bedroom
Shower
1/2 bath
Hall & Closets
<-- Represents half wall
Front of Duplex
Incompletes lines on walls imply a doorwa

- Each side should have a backyard where women can establish their own sitting area and possibly a garden distinct from the broader compound. This area should not be fenced off.

- Small offices should be provided for the coordinator and the community integration worker (CIW) as well as a shared back office to be used by DBT workers and clinical staff in the duplex so that staff roles are integral to the setting and maximize interaction with the women and staff. There should be an outside door into the staff lounge so that staff can come and go without having to move through the duplex.

- The staff space should be divided by the main wall separating the sides of the duplex with a solid door in between the sections to maintain each setting as a separate living environment, while allowing staff to move quickly back and forth when needed. Staff should be provided with their own bathroom and a small lounge.

- A multi-purpose meeting and program room should be provided for individual interviews and group DBT programming. It also provides a meeting space within the setting, allowing DBT workers to attend meetings while also providing staff supervision if necessary. It should have a movable room divider to separate the two halves.

- The front and back doors should have an attached buzzer system which would warn staff of women leaving and entering the building if it is activated.

Finding: t is important to provide women with emotional distress needs and severe behavioural difficulties with a small group living environment which simultaneously provides a home-like appearance that mirrors community standards, while also insuring safety and security in instances of acting-out behaviour. Staff expertise and input from women offenders is required to balance these design criteria.

Recommendation 19: Plan and construct a duplex house with up to four women living on each side at the regional facility utilizing the proposed structure and criteria as a starting point for planning. he architects must utilize staff expertise, and input from relevant women offenders, to plan the house. The program coordinator must be hired as soon as possible such that the coordinator is able to facilitate staff and woman offender input into the design. A committee made up of the lead architect, the builder, the warden, and the DBT coordinator must have the final authority on all phases of the design and construction process.

Daily Living Expectations and Skills Application

The women offenders should be responsible for daily living tasks such as cooking, cleaning, laundry, and budgeting according to the same provisions as the regular houses. Based on the admission criteria of skills competency in these areas, they should not require practical assistance in performing these tasks. However, given their emotional instability and difficulties with relationships, there are likely to be difficulties in the process of working together and completing tasks. These difficulties will be valuable learning opportunities in which staff can coach and facilitate the women offenders to apply the core DBT skills to daily living problems. Relative to the PSR program, staff facilitation will involve assistance with problem-solving and coping strategies rather than hands-on teaching with respect to tasks. Staff should try to address relationship and problem-solving issues in the daily house meetings and allow the women to work out problems themselves to the greatest extent possible, but individual coaching and crisis intervention will likely be required in individual situations. The question of whether staff are present during periods such as meal preparation will vary with the needs and interactions of the women. It may be preferable to stay out of the setting to allow the women to interact on their own in some instances, while in other situations distant supervision through remaining in the staff office, or immediate staff presence and participation, may be appropriate.

Whereas in the PSR program, staff will be encouraged to eat with the women, this will be a daily decision with the DBT program, balancing the desire to maintain the setting as an independent living environment for the women with the value in informal interaction between the women and staff at meals. There should be budgetary provision for one staff member to eat with the women though it would be used less frequently than in the PSR program.

The amount of structure in daily schedules for individual women will vary with the needs of the women, but choice should be maximized within the boundaries of the individual being able to make safe choices for herself and others.

Informal interaction and leisure opportunities between individual women, and between individuals and staff are an important means to develop the trusting relationships and provide opportunities to address problem-solving and coping issues through the application of the core skills. Staff in the setting would be expected to participate in positive informal interactions so as to build relationships without fostering dependency.

Recommendation 20: Staff should utilize informal interactions as a means to foster trusting relationships with the women. Emphasis should be placed on using difficulties resulting from conflicts generated by relationship and/or daily living tasks as opportunities for individuals to apply their coping and problem-solving skills to practical situations. The amount of staff supervision may vary over time in relation to the specific grouping of women. It should balance needs for staff to develop strong relationships with the women, to provide for the safety of everyone, and to foster the independent functioning of the women.

Work, Learning, and Leisure Programs and Skills

Emphasis must be on insuring that they are fully integrated into the general population with respect to leisure opportunities as the expectation is that they will eventually move into a regular house or an unsupported community living situation.

Recommendation 21: Excepting their involvement in DBT specific program components, women in the duplex would participate in general programming in relation to their correctional plans like any other woman offender.

Behaviour Management in the Living Environment

The effective implementation of a positive DBT process, the investment of the women in the program, and the structure and support of the program and staffing should reduce behavioral difficulties over time. However, these women have long-term behavioural difficulties that will inevitably manifest themselves and they must be addressed effectively in a team context. For women with emotional distress needs, consequences must be immediate, direct, consistent, and based on natural contingencies. Specific approaches must be applied consistently across the staff team so that an individual knows what is expected of her.

There is a potential serious conflict between the emphasis on individuals taking responsibility for their behaviour utilizing DBT skills which is fundamental to these women establishing hope, confidence, and a stake in their own lives, and behavioural programs and consequences that staff utilize to manage difficult behaviours. Acting-out behaviours require consistency and actions which typically remove control from the individual woman and reinforce dependency. If staff interactions with individuals are dominated by behavioral plans then it is difficult to develop genuine and trusting relationships with them. There is a very fine line between the need to take consistent action to manage behaviour and contravening key values of the dialectical behaviour therapy program. Several important elements are required to effectively walk this fine line:

House Expectations and Natural Consequences: Any group of people requires basic expectations in order to live together in a cooperative manner and these expectations need to be clearly defined by the women and staff in the setting at the outset. Failure to live up to these expectations should invoke natural consequences as opposed to "personal" consequences aimed at behavioral control of the individual. For example, if a woman does not fulfill her meal preparation responsibilities and others fill in for her at the last minute, then she may have to take an extra turn in addition to repaying the turn she missed to make up for the inconvenience she caused others. This may need to be a standard policy or else relationship dynamics might result in one woman not wanting to invoke it in one instance in which she is filling in for a friend while she demands that it occur in another instance involving a woman with whom she is irritated. A "personal behaviour" consequence and a "natural" consequence may in some instances be very similar with respect to the actual result but the interpretation and process of developing them is different. In the first instance it is perceived as a staff response to control of an individual's behaviour while in the latter instance it is an expectation set by all of the members of the setting (including staff) and implemented by staff as a part of their role in the setting.

A Balanced Dialectical Approach: The dialectical behaviour therapy model specifically focuses on therapeutic skills which assist practitioners to balance and shift intervention strategies in relation to extreme behaviour exhibited by individuals in order to coax the women to move toward a middle behavioural path. Thus practitioners must balance acceptance and change, unwavering centredness (fixed positions) and compassionate flexibility, and nurturing and benevolent demanding (caring challenges). Staff expertise in applying these dialectical strategies should be particularly valuable in balancing actions to manage the potential conflict between behavioural control and independent functioning.

Multi-Disciplinary Team Meetings and Communication: The development of balanced and consistent approaches to behavioural problems is a very difficult task requiring multiple perspectives and a high level of communication among staff. This is particularly important in that women with high emotional distress needs are often experts at dividing staff and putting them in conflict with each other. Dialectical theory can be valuable in facilitating the staff communication process in that it recognizes the validity of diverse responses and provides a framework for staff to discuss and integrate them. Formal multi-disciplinary team meetings should be held weekly to discuss the progress of the women in the program and to serve as a means to coordinate efforts and work on projects in smaller groupings. They should involve all of the key staff members in the program including the coordinator, psychologist, nurse, community integration worker, as many DBT workers as possible, and as many other staff as is possible who are relevant to the current work. Specific steps must be taken to structure DBT workers' participation, and funds must be budgeted to allow for it. Scheduling options include:

- holding the meeting across the change of shift.
- providing compensatory time for staff attending the meeting to be used at a later point.
- meeting when the women are out of the house so that staff on shift can attend.

Careful Reflection on Staff Values, Interaction Styles, and DBT Values: It is imperative that staff reflect on their own values, DBT assumptions, and their own behaviour and style of interaction as a means to considering specific responses to behavioural issues. Difficulties may be avoided in some instances if staff intervene in a preventative manner, while in other instances it may be important to ignore the situation, or to recognize that the behaviour may only be problematic for the staff rather than for the functioning of the individual or the safety of the setting. These decisions and strategies require team communication, a shared vision of the program, and a foundation in dialectical behaviour therapy and behaviour management. Staff training and team building are important elements to achieving success.

Continuum of Quiet Options: Another key element of behaviour management is working with individual women in order to improve their coping and problem-solving skills with respect to specific stresses. They require a continuum of options through which they can take steps to apply the core skills to their stresses and control their behaviour, and/or ask for help from staff. There must be space to "get away" within the setting when they are under stress. The options should include:

- enabling their bedroom to be a relaxing spot through their ability to decorate and control its appearance, and by insulating it from sound from the rest of the setting.

- establishment of an outdoor quiet spot behind each side of the duplex where a woman can relax.

- provision of a den/quiet spot in the setting as an alternative refuge which is attractively furnished, well lighted, and insulated for sound.

- provision of therapeutic quiet, a safe room which can be locked and viewed by camera. A woman should be able to ask to enter therapeutic quiet for her own safety, or she may be placed there for her own safety by staff according to specific policies and procedures.

Recommendation 22: Staff must balance the need for hope and personal motivation inherent in dialectical behaviour therapy with the need to cope with offenders' behavioural difficulties. Setting the appropriate balance should involve the use of group defined house expectations, natural contingencies, dialectical concepts, multi-disciplinary team meetings, staff reflection on values and interaction style, and a continuum of quiet options.

Therapeutic Quiet: Therapeutic quiet is an essential element of the duplex design and must be regulated by specific procedures developed for the setting. Women with emotional distress needs may be at risk for self-harm such that they may seek or require short-term, externally locked control, be it for a few minutes or a few hours. However, lengthy isolation is counter-productive as the offender loses focus on why she is isolated and she may become more desperate, hopeless and dependent. Invoking segregation is often inappropriate and perceived as punitive for the circumstances, yet a brief therapeutic quiet option is required to insure the safety of the woman. The psychologist should work with the staff team in consultation with the institutional administration to define specific written procedures for the use of therapeutic quiet. The psychologist should consult with the programming team at the Prison for Women to draw on their expertise and experience with the use of therapeutic quiet with these women with special needs. It will be essential to train and support staff to use therapeutic quiet effectively. In some instances, women who may have been in other institutional settings where therapeutic quiet is very accessible for voluntary locked use, will need to be weaned toward utilizing less intrusive quiet options since therapeutic quiet is not a characteristic of the regular houses or community living settings.

Recommendation 23: Therapeutic quiet must be an essential element of the duplex design through which women can learn to better manage stressful situations, and through which they can be secured when a danger to themselves. Specific written procedures must be developed to monitor its use. Staff must be effectively trained in the use of therapeutic quiet.

Bridging to Regular Houses

It is essential to build in a program expectation that a woman will progress to a regular house if and when she has improved her behaviour so as to be able to function more independently, given that an independent level of functioning will be required of her upon release. The expectation of graduation and the positive recognition and sense of accomplishment that goes with it, must be a basic assumption and norm in the setting. Resistance to shifting to a regular house may be a difficult issue with some women as they will value the relationships they have developed in the DBT setting and fear change. The smaller group living situation of the duplex may also be attractive to them relative to the regular houses. An important element in facilitating this move will be insuring that the woman's individual relationships can be maintained with staff and that she can continue to participate in individual DBT counseling and group skills training after she leaves the duplex, if it is appropriate. In addition, the women in the DBT program should have the same daily task expectations as women in the regular houses and should be fully integrated into all programming as is appropriate to their interests and needs so that they develop relationships outside of the DBT program. Although the expectation of moving on is important, it is also likely that some women will be released before such a shift is advisable.

Bridging for Community Integration

Linehan (1993) notes the tendency for women with borderline characteristics to function at their best in stable relationships, and yet fall apart without them, as an important attribute of the grouping. One woman interviewed as a part of this research, who was planning to move to a medium-security facility, articulated this directly in noting that her major fear was that she would have to relate to new people, and that she would have great difficulty seeking help from them when she was in trouble. Fear of abandonment is also a key characteristic of these woman (Linehan, 1993) and though they must work through it, a slow change in relationships is required rather than an abrupt shift to a new setting.

The present relatively impersonal and abrupt community release process of handing a person to new community correctional staff and support persons across jurisdictions is a recipe for recidivism for these women precisely because it does not provide for an initial consistency in supportive relationships and then a gradual transfer of these relationships as a part of the transition to community settings. If transitions are not slow and supported by stable relationships, these women are likely to act out due to a fear of abandonment.

The key community integration worker must be based in the institutional program such that the foremost priority is to build a strong relationship with each individual woman to assist her in moving to the community. It is not possible to develop this type of relationship with these women if the worker is based in the community and can only come to the institution periodically. However, it is possible for an institution based worker, who has a strong relationship with the individual offender, to go to her home community and develop effective relationships with community support organizations and workers so as to facilitate the transition.

Community Integration Worker: A specific staff role and process is proposed for the DBT program which has the primary purpose of providing the bridge between the work in the penitentiary with the woman and the community living situation and support system of the woman upon release. The key elements of the "Community Integration Worker" role are:

· to develop a trusting relationship on an individual basis with the offenders through informal and formal interaction.

· to participate in the release planning process for the woman developed through the woman's partnership with her DBT worker.

· to assume primary responsibility for case management functions in consultation with her DBT worker once the individual enters the DBT program.

· to establish contacts and visit the release community to advocate for, negotiate, coordinate, and create support systems for release, in partnership with the woman based on her release plan.

· to provide education to persons and organizations who will provide community supports upon release with respect to the needs, goals, and experiences of the individual woman.

· to accompany the individual upon release and to support her in the community living situation for a transition period as is appropriate. This might involve remaining in the release community for a number of days.

· to visit the woman in the release community with some regularity while monitoring and continuing to educate and help problem-solve with key staff in the community support system.

The Community Integration Worker is essential to maximizing the likelihood of success in the woman adjusting to the support system upon release so as to reduce the potential for recidivism. This individual requires strong interpersonal skills to develop trusting relationships with the women, a hopeful, persistent and direct approach in order to advocate for resources, and sophistication in coordinating and educating community support workers.

The community integration worker would work with all offenders in the DBT program, some of whom might have participated in the program without ever living in the duplex, while others may have shifted to a regular house prior to release. There should be a limit of 14 women for the caseload of the community integration worker or else the person will be unable to fulfill the on-going support and bridging function for the women moving to the community.

Financial Resources for Community Integration. Each community release process and correctional plan will be unique to the needs of the individual and local resources. Standard community correctional centres with a majority of male residents and a large group living situation are most frequently inappropriate for the release of these women. To facilitate community integration and effective individual release plans, funds must be budgeted within the DBT program to allow for:

- frequent travel to communities across the region to facilitate release plans.
- travel on an occasional basis by key community support workers in order to facilitate an understanding of the woman's experience within the penitentiary setting.
- additional contracted, community workers to support the women through a longer transition process in the community if necessary.

Finding: The present correctional release process is ineffective for women with emotional distress needs and severe behavioural difficulties due to its failure to provide a bridge of consistent relationships for the women from the penitentiary to community settings. These women require consistent relationships to make a successful transition across settings. Behavioural gains made in the DBT program will be lost, including a greater likelihood of recidivism, if there is not consistent and effective support provided in transitions.

Recommendation 24: There must be an alternative release model in which a community integration worker builds a strong relationship with the individual woman in the penitentiary and then uses this relationship as a bridge to establishing her in a community setting. The community integration worker must be based in the institution in order to develop the strong relationship with the individual offender that is required for success. Sufficient funds must be provided to support this community integration process. Consistent relationships with DBT staff must also be maintained if a woman moves from the DBT duplex to a regular house within the penitentiary.

Staffing Complement, Qualifications, and Roles

The following staff complement is proposed for the DBT program for a maximum of eight woman offenders living in the setting and six living in the general population. This complement is above any existing staff already present in the penitentiary. The complement should be:

- 1 full-time program coordinator/psychologist (or DBT specialist)
- 1 DBT worker on the day and evening shifts, seven days per week with an additional DBT worker on the five weekday shifts (one of these DBT workers should be a psychiatric nurse, and their should be the ability to call in a second DBT worker on a shift if required)
- 1 community integration worker
- 1 FTE psychologist, preferably 1/2 time each for 2 persons
- 1 night security staff (may not be required depending on the

individual offenders in the house)

· 1 day per week for an evaluation consultant (preferably this would be an additional 1 day per week for the psychologist, if either one has the required skills)

· consulting general physician, psychiatry, chaplaincy, First Nations Elders, and community resource persons as per any offender

This complement is high relative to the existing complement of the regional facilities. However, it must be recognized that the purpose of this program is to transfer and maintain high-needs offenders presently in maximum-security facilities to the regional facilities. This staffing complement is low relative to the resources presently provided within maximum-security facilities. A significant part of the reason that these women have not been in, or have had serious difficulties in regional facilities, is because there have been inadequate staff resources to support them.

Program Coordinator Role and Qualifications. The program coordinator should have the minimum qualifications of...

· a registered psychologist with expertise in cognitive-behavioural approaches or a graduate- trained mental health practitioner with extensive expertise and experience in DBT,

· demonstrated skills and interest in working with women with serious emotional distress,

· core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,

· an interest in and willingness to commit to a dialectical behaviour therapy approach,

· strong, demonstrated organizational and interpersonal skills to manage and facilitate the multi-disciplinary team.

It is essential that the program coordinator be fully committed to a DBT approach in order to provide appropriate leadership and supervision to the team. There should be a strong preference for a person who also has experience in corrections. Recruitment of a competent individual to fulfill this role, as well as the other psychologist roles, may be difficult because psychologists are generally scarce in corrections in Ontario. An active recruitment process will be required and it should include consultation with persons across North America who are specialists in DBT. A Ph.D. psychologist with correctional and behavioural experience should play a key role in the recruiting and selection process in consultation with the psychologists and management team at Grand Valley Institution. The hiring team must also include a person with particular knowledge of DBT and familiarity with DBT networks. Access to psychology and DBT networks will be an important resource in conducting a successful search. The coordinator must be hired first in order that the person can take the lead role in hiring all other program staff in consultation with the Grand Valley management team, and senior staff at P4W who are familiar with DBT programming with these women.

The coordinator must be responsible for the overall direction of the program and supervision of the staff, particularly with respect to clinical treatment issues. This position should be approximately half time leadership and administration and half time clinical work with the women offenders. The coordinator is expected to take on an individual caseload of four women for individual DBT work. The coordinator should work cooperatively with staff members and the woman offenders to define the program.

DBT Worker Role and Qualifications. The DBT workers should have the minimum qualifications of...

- a university degree in a social sciences, human services, or health field, and/or equivalent,
- demonstrated skills and interest in working with women with serious emotional distress,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- demonstrated, effective interpersonal skills,
- an interest in and willingness to commit to a dialectical behaviour therapy approach.

Preference should be given to workers presently at the facility if other qualifications are equal. One DBT worker should be a nurse with psychiatric training in order that this expertise be an integral part of the staff team.

Individuals should be required to voluntarily apply for these positions and they should be interviewed and selected through a formal hiring process. Additional casual DBT workers will need to be hired to fill in occasional spots in the rotation and to be available to move into the program quickly if full-time DBT workers leave with little notice or take leaves of absence. These casual DBT workers should receive the full DBT training but should be assigned other duties in the facility if possible when they are not required in the program. Overall, the staffing should be allocated so as to minimize regular part-time workers as they increase the size of the staff team and make team consistency and communication more difficult.

The DBT workers should work exclusively in the program on a three-year term basis on day and evening shifts. At the end of that term it would be the decision of the coordinator in consultation with the DBT worker as to whether the person would continue for another term or shift to another role in the facility. This would provide the opportunity for rotation and relief for individuals as work with these woman offenders can be extremely draining over time. It also would give the opportunity to provide a cross-pollination of ideas and concepts between the DBT program and staff working with the general population.

The DBT worker role should involve direct, informal support work and coaching with the women in the setting, primary responsibility for DBT group skills training programming, individual case management with one or two individual women, and monitoring of the setting as required. The DBT workers should report to the program coordinator and must participate in the full DBT training program.

Night Supervision and Staffing. The level of supervision required on the night shift is difficult to specify as it depends on the individual needs of women in the duplex. It is expected that regular checks on rounds may be sufficient at least some of the time, but if individuals are upset, there may be a need to provide direct supervision through the night in the house. The capacity must exist to call in staff for this function.

If night staffing becomes an on-going need, the night shift should not be staffed by DBT workers from the program. The night shift does not provide an opportunity for them to carry out their key roles of building relationships and providing programs to the women. If they are placed on the night shift, it will require more program DBT workers to staff the duplex which in turn results in more staff with whom the women in the house must develop relationships, and these staff would be present during the days less frequently. This does not meet the needs of the women offenders who have difficulty developing relationships with larger numbers of staff and who require a consistent approach from a small staff team. Staff communication and informal consultation become more difficult, particularly with respect to facilitating a weekly meeting with most of the staff present on the day shift. If required on a regular basis, the duplex should be staffed at night by a different set of workers whose function is to provide supervision if a woman is upset or wakes up. These staff must be regular Correctional Service of Canada employees who are able to intervene with the women when required.

Psychologist Role and Qualifications. The psychologist(s) should possess the following qualifications:

- registration as a psychologist,

- demonstrated skills and interest in working with women with serious emotional distress,

- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,

- an interest in and willingness to commit to a dialectical behaviour therapy approach,

- demonstrated, effective interpersonal skills.

The psychologists (if there are two) should each be responsible for individual work with five women offenders in addition to participating in and supporting other clinical aspects of the DBT program. It would be preferable to have psychologists who would be working in the facility in other roles such that they would have a full-time presence at the facility.

Community Integration Worker. The community integration worker should possess the following qualifications:

- a master's in social work and/or equivalent,
- demonstrated skills and interest in working with women with serious difficulties/disabilities,
- core values which include hope, empathy, respect, connection and empowerment that have been demonstrated through the person's work,
- strong, demonstrated, interpersonal and advocacy skills,
- creative initiative in problem-solving,
- training and/or experience in developing and coordinating community resources,
- an interest in and willingness to commit to a dialectical behaviour therapy approach.

The community integration worker would serve fourteen women and the role has been described previously.

Spirituality. Dialectical Behaviour Therapy views recovery as a holistic process with a foundation of positive values. A commitment to spirituality is an important pillar of support that should be strengthened in relation to the women's interests. The chaplain can play a valuable role through developing individual relationships with the women and supporting their spirituality.

Psychiatric Nurse Role. It is important to have a registered nurse with additional psychiatric training and/or experience as a member of the staff team and this could be assured by requiring this expertise of one DBT worker, who would likely work a greater percentage of day shifts. The nurse should take responsibility for coordinating work with the institution's health care nurses and physicians for the women in the program. Physical complaints and drug-seeking behaviour are very common among women with these needs. It is complex and important to separate out legitimate uses of medication from drug seeking and it is difficult for doctors during brief consultations to gain the full picture without the presence of a well-informed nurse. The nurse is responsible for ensuring there is a consistent team approach to medical treatment.

Support for Cultural Diversity. Given the small group context, an individual woman from a First Nations, African-Canadian, or other distinct minority culture is likely to be isolated from her own cultural context in her living situation. It is essential to involve resource persons who can share and support her culture as an integral part of the treatment process. Provision must be made for key support persons to participate in elements of the DBT training process in order that they appreciate the approach, and recognize its strengths and limitations in relation to the woman's cultural background.

Finding: High quality and committed staff are essential to an effective program. They must be committed both direct work with difficult women and to the DBT program model. Although staffing is expensive for a program for these women with special mental health needs, insufficient or poorly trained staff will result in failure. This staffing level is lower than the level of a maximum-security facility where these women would otherwise be maintained.

Recommendation 25: It is essential to select staff with strong interpersonal skills and values for work with these women while allowing for a mix of expertise to provide for diverse perspectives. Programming will be most effective if there is a small, multi-disciplinary staff who can support each other and provide a consistent approach to work with the women. Core staffing should include a program coordinator/psychologist, one DBT worker on day and evening shifts, a second psychologist, a community integration worker, and a program evaluation consultant. Night shift staff, if required, should not be DBT workers in the program and should be limited to a security and supervision function. Core part-time staff positions should be avoided wherever possible as their intermittent presence makes communication and coordination more difficult. It may be difficult to fill the coordinator position and it is recommended that senior staff from the Prison for Women assist with the recruitment and hiring process for key staff, as well as a professional with specific DBT expertise..

Staffing Training, Support, and Communication

Staff Training. Dialectical Behaviour Therapy is a precise, logical approach that requires practitioners who have a fundamental grounding in the approach and the skills to apply it. Staff must bring a strong values foundation and set of interpersonal skills to the work and then must receive detailed training to be able to apply the approach with women who have great difficulties and can be extremely demanding of staff. An intensive staff training program for the program coordinator, psychologists, and DBT workers should include:

- a multi-week DBT training curriculum
- two weeks devoted to team building, program planning and evaluation, and selected mental health topics and communication skills

The DBT training curriculum should be developed in consultation with Marsha Linehan and DBT specialists based at the University of Washington. It should include practical experience, supervision and feedback as well as participation in formal training sessions. A team curriculum will be required but there may also be the need for distinct packages for different staff roles in order to supplement it:

- the program coordinator, as well as other key staff, if they have limited experience in DBT, should spend time visiting DBT programs which involve correctional populations. These may be suggested by the DBT specialists at the University of Washington.

· DBT workers may require a training program on basic cognitive-behavioural techniques if the DBT curriculum assumes that background. DBT workers may also require specific additional training and supervision with respect to teaching the group-skills curriculum.

· direct supervision and feedback, possibly involving videotaped sessions should be provided to the psychologists conducting the individual sessions with the women offenders.

A number of options may be appropriate for structuring a full training package but it must be in-depth and provide the opportunity for staff to learn through the practical application of the concepts and skills in direct work with female offenders. The Senior Project Manager for Mental Health Services at National Headquarters has already coordinated an introductory DBT workshop for Correctional Service of Canada staff. Her expertise and relationships in working with the DBT trainers at the University of Washington should be utilized in defining and coordinating the training process.

A brief one-two day training program should be provided for potential night security staff, the chaplain, health nurses, contract programmers, relevant Elders and community resource persons, etc. This program should be organized and facilitated by the program coordinator. Staff hired from outside the correctional system would be expected to participate in the standard training programs for work with women in corrections which are required of all staff.

Support and Communication. The program coordinator, staff team, and the institutional administration must recognize the importance of on-going team support and communication to make this program effective as these women are extremely demanding on staff. Staff can quickly lose perspective and patience if they do not have communication and support within the team and from the broader facility. There should be a peer supervision process for those providing individual counseling with the women and it might include an experienced therapist from outside the program in order to provide an independent and fresh perspective. This commitment to team and communication must come from the individual staff but it requires an administrative context in which the legitimate use of staff time for team meetings, informal consultation, and support is recognized and supported. In particular, there must be opportunities on a regular basis for all of the key staff to meet together at one time. This requires funds to bring in or replace DBT workers.

Finding: Effective staff-training and support is essential to the success of the program and the ability to attract and retain quality staff.
Recommendation 26: All core staff must participate in a DBT training program designed in consultation with DBT specialists at the University of Washington. plus two weeks of training on team-building, program planning, evaluation, and selected mental health topics. A brief training program should be provided for auxiliary staff. There must be on-going commitment and resources for staff communication and support, including supervision and peer support for

the individual therapists.

Program Evaluation

Given that this program represents a major new initiative involving high-needs women, program evaluation must be built into the process from the outset and should include a blending of qualitative and quantitative approaches with process and outcome measures. There are two options for obtaining program evaluation expertise. Preferably, a psychologist would have significant program evaluation expertise (possibly with some continuing education) and could design and carry out the evaluation in consultation with the team and the women. In the developmental phases of a program there are particular benefits to internal evaluation processes in that they encourage the staff team to build a continuous quality improvement ethic into all of their work on a daily basis. However, if there is no one with this particular expertise on the team, then an external contract should be tendered for a professional to design and complete the evaluation work in consultation with the staff team and the women offenders. It is expected that the evaluation would require one day per week for the first two-year period. If the psychologist took on the evaluation role, they would require an additional day per week to fulfill the task.

Finding: Program evaluation is essential to program improvement and accountability.
Recommendation 27: Either the psychologist or an external consultant should design and conduct the program evaluation in consultation with the staff team and the woman offenders.

Obstacles to Effective Implementation of the Program

The following issues could become major obstacles to the implementation of an effective program and therefore must be recognized and strategically addressed from the outset:

1. Failure to hire and/or maintain quality staff. Strategies to avoid this problem include:

- the provision of adequate time and attention to hiring, including an active recruitment process.

- ensuring there are individuals on the hiring committee who have direct experience working with these women and this type of program.

- drawing on existing staff who have demonstrated exemplary performance for the DBT workers positions.

- an administrative and resource priority on providing time for staff training, support and communication.

2. Conflicts with broader penitentiary policies and requirements. Potential strategies to avoid these problems are:

· a clear vision and written program description recognized throughout the institution which allows for a relatively high level of program autonomy.

· a formal, documented multi-disciplinary admission process with clear criteria that is honoured at the institutional, regional, and national levels.

· initial start-up planning time involving the administration and staff team in order to identify and problem-solve with respect to potential policy conflicts.

· a flexible administrative approach to the program and a willingness to support staff judgment.

· a staff team with correctional experience that recognizes policy concerns in a penitentiary.

· on-going efforts by the staff team to educate other staff and women offenders about the purpose, practices, and challenges of the program. Recognition by the staff team of the potential of resentment from other staff with respect to new resources for a new program when existing resources are limited.

· program participation in regular communication forums at all levels in the institution.

3. Inability of the staff team and the local administration to control planning decisions. Potential strategies to avoid this problem are:

· ensuring that staff are hired and in place in advance of program-start-up. This includes hiring key staff as soon as possible, even if they perform some other functions initially while the planning and implementation process gathers momentum. Pressure must be resisted to proceed too quickly given the priority on transferring individual women out of maximum-security environments.

· ensuring that there are effective mechanisms for staff control and input into the building design at a detailed level so that the structure reflects programming and security needs. Problems in the physical structure can be a permanent drain on the program and staff.

· ensuring that the program has flexibility with respect to policies and procedures wherever appropriate.

4. Ineffective team communication processes and insufficient support for staff. Potential strategies to avoid this problem are:

· ensuring that the program coordinator is a skilled group facilitator and that there is attention to team building initially and on a continued basis.

· providing sufficient time for team meetings and informal consultation. Insure that DBT workers are available to attend team meetings.

· providing effective staff training and expect a commitment of all staff to work within a DBT philosophy and to utilize it as a framework to discuss differing staff perspectives with respect to the individual women.

· supporting a program atmosphere which allows staff to take risks and make mistakes in a team context.

Recommendation 28: Specific strategies must be adopted from the outset to overcome these obstacles to the effective implementation of the PSR program with women offenders..

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The proposed psychosocial rehabilitation program for women with basic skill needs and cognitive challenges and the dialectical behaviour therapy program for women with emotional distress needs and severe behavioural difficulties represent important new initiatives in relation to realizing the vision that was initially defined in *Creating Choices* by the Task Force on Federally Sentenced Women (1990). Up to this point the regional facilities have only provided one living option that has not met the needs of women with special mental health difficulties. As the result, these women have either ended up in difficult and often explosive situations in the regional facilities or have had to remain in maximum-security facilities. These two program models are a major step toward actually *implementing choices* at the regional facilities. They require more resources than is now allocated to programs at the regional facilities, but they require fewer resources than what is now allocated to maximum-security facilities. It must be recognized that these models will only be effective if they have quality staff and a significant level of resources committed to them. The costs will be much higher if these women have to remain in maximum-security facilities or serious incidents result from insufficient support for them at the regional facilities. In the long run these programs offer the promise of helping these women to make a successful transition to the community, for their own benefit and that of the society.

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Nova Institution, Truro
Inmate Committee (twice)
Staff Assembly (twice)
1 Women Offender with Mental Health Needs
Warden- M. Ennis
Deputy Warden- J. Butterworth
Head of Programs- A. M. MacDonald
Psychologist- S. Frausen
Case Management Officer- R. McDonald
Shift Supervisors (R.O.S.)
Chaplain & Educational Programmer- P. Noseworthy
Art Educator- C. Sandeson
Life Skills Programmer- D. Yetman
Former Occupational Therapist- L. Shimmel (by phone)
Team Leader of Management Services- G. Baker
Union Representative- K. Fowler
Former Structured Living House Worker- W. Cavanaugh
Atlantic Regional Advisory Committee for Creating Choices
Primary Workers- T. Lambswood & T. MacMillan
Substance Abuse Programmer- B. Putnam

Atlantic Regional Office
Women Offenders Consultant- F. Allen
Project Advisory Committee (twice)

Springhill Institution: Women Offender Unit
6 Women Offenders with Mental Health Needs
Former Unit Supervisor- K. Comeau
Unit Supervisor- K. MacKenzie
Unit Case Management Officer- B. MacDonald
Unit Security Officers (3)
Deputy Warden- A. Alexander
Former Unit Manager- S. Poirier
Unit Psychologists- R. Simmons & B.J. Cormier
Director of Psychology- J. Earl

National Headquarters, Ottawa
Deputy Commissioner for Women- N. Stableforth
Senior Advisor for Women- S. Lyth
Senior Project Manager Mental Health- J. Laishes
Projects Assistant- J. Macdonald
Women Offenders Maximum-security Interview Researcher- D. McDonagh

Grand Valley Institution, Kitchener/Waterloo
Warden- M.-A. Drouin
Senior Management Team
Representatives from the Citizen's Advisory Council and the Elizabeth Fry Society
Inmate Committee

Prison for Women, Kingston
5 Women Offenders with Mental Health Needs
Manager- L. MacDonald
Multi-Disciplinary Meeting
Director of Programming- F. Tobin
Behaviour Science Technicians (2)
Psychiatric Nurses- L. Fumerton & M. Evans
Chaplain
Deputy Warden

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